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Cultural Differences, Social Support, and Therapy Outcomes: A Comparative Study Between Individualist and Collectivist Cultures

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CULTURAL DIFFERENCES, SOCIAL SUPPORT, AND THERAPY OUTCOMES:
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By

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CULTURAL DIFFERENCES, SOCIAL SUPPORT, AND THERAPY OUTCOMES: A
COMPARATIVE STUDY BETWEEN INDIVIDUALIST AND COLLECTIVIST CULTURES

This dissertation, by Veronica Felstad, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
Antioch University Seattle at Seattle, WA in partial fulfillment
of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

CULTURAL DIFFERENCES, SOCIAL SUPPORT, AND THERAPY OUTCOMES: A

COMPARATIVE STUDY BETWEEN INDIVIDUALIST AND COLLECTIVIST CULTURES

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Seattle, WA

Social support plays an integral role in our lives, and recent research demonstrates that the

presence or lack of social support has a potential impact on factors of interest to psychologists,

such as therapeutic progress and therapeutic alliance. There is a lack of research demonstrating

the relationship between social support and treatment outcomes and the role culture plays. This

quantitative international study aimed to explore cultural variances in perceptions, utilizations,

and functions of social support, particularly between individualist and collectivist cultures, and

the potential effect these variances had on the relationship between social support and

therapeutic outcomes. Sixty clients and eleven therapists, divided among Bogota and Seattle

counseling centers, participated in this study by completing pen- and paper-based questionnaires

that included measures of social support, client's perception of therapy progress and therapeutic

alliance, and therapist's perception of therapy progress and therapeutic alliance. Using

nonparametric testing the study sought to find differences and similarities among these factors.

Additionally, it explored whether culture had an impact on how people perform in therapy and

the relationship between their therapeutic alliance and relationships outside of therapy. Results

revealed no significant differences or similarities although paving the way for further research.

This dissertation is available in open access at AURA: Antioch University Repository and

Archive, http://aura.antioch.edu and OhioLINK ETD Center, https://etd.ohiolink.edu/etd.

Dedication

I would like to dedicate this project to my father. He has always told me, "La vida te puede quitar todo, menos la educación" which translates to "Life can take it all away, except for your education." Thank you for instilling the value of education in me and for pushing me to follow my dreams and pursue a doctorate degree. Thank you for setting forth that example. I admire you and all of what you had to sacrifice to get an education. This has made me want to work hard and be someone in life. You have always kept the hunger for learning and have strived to be better every day. Although, life has placed great distance between us, it has never been able to separate us. Te amo, Papi.

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I would like to offer my deepest appreciation for all the support, guidance, and productive feedback by my dissertation chair, Chris Heffner, PsyD, PhD I would also like to extend my gratitude to my committee members, Dana Waters, PsyD and Juan Camilo Restrepo, PhD for their continuous counsel, careful reviews, and understanding. I would like to express a special thanks to my husband, Chris, for all his unconditional love, support, and patience through this rigorous process. Finally, to my family for always giving me the encouragement I need to propel forward.

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CHAPTER I: INTRODUCTION

In recent decades, extensive research has focused on social support and its influence on many aspects of mental health. Social support is defined as a multidimensional concept that speaks broadly to the characteristics and functions of an individual's connections within their social environment (Lourel, Hartmann, Closon, Mouda, & Petric-Tatu, 2013). Social support plays an integral role in our lives, and recent research demonstrates that the presence or lack of social support has a potential impact on factors of interest to psychologists, such as therapeutic outcomes (LeGrand, 2010; Lourel et al., 2013; Northey, 2011; Ogrodniczuk, Piper, Joyce, McCallum, & Rosie, 2002; Silverman, 2014). Based on the common factors theory, this research defined therapeutic outcomes as the combination of perceived therapeutic progress and perceived therapeutic relationship/alliance (Norcross, 2011, Northey, 2011). Research suggests correlations between social support and therapeutic outcomes exist (LeGrand, 2010; Lourel et al., 2013; 2010; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014). To date, research does not show the relationships between social support and treatment outcomes relative to the role culture plays. Thus, the present research represents a novel effort in exploring cultural variances in perceptions, utilizations, and functions of social support, particularly between individualist and collectivist cultures. Additionally, it explores the potential impact these variances have on the relationship between social support and therapeutic outcomes.

Statement of the Problem

There is considerable research demonstrating that social support affects wellbeing and therapeutic outcomes, however, there is no research that explains the differences and similarities social support and therapeutic outcomes have in collectivist and individualist cultures. Consequently, there is a lack of adequate measures and screening tools to evaluate social support

and its relationship with culture and the impact on treatment.

Research shows that use of screening tools that measure individual's social support as it relates to therapeutic outcomes has mainly occurred in laboratory settings and controlled research, as opposed to its use in clinical practice (Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014). Social support can be an underrepresented issue when it comes to therapy (LeGrand, Lourel et al., 2013; 2010; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014), meaning that not enough emphasis is put on the relationships outside of therapy in order to aid the therapeutic process and therapeutic relationship.

Significance of the Study and Clinical Implications

The detrimental effects of stressful life events on physical and psychological health, combined with the innate social nature of our environment, bring to question the validity of therapy alone absent utilization and integration of social support factors (Procidano & Heller, 1983). The evidenced lack of utilization of social support measures in therapeutic interventions, the potential impact of social support factors in therapy, and the largely unknown cultural differences that may impact social support in therapeutic interventions reflects important implications and offers a large contribution to the field of psychology.

This study's clinical implications were twofold. First, it aimed to help clinicians understand and increase utilization of social support factors in interventions. Second, it sought to increase awareness of multicultural treatment factors in the field of psychology.

Purpose and Goals of the Study

This study explored the collectivist and individualist cultural differences in Perceived Social Support (PSS) as it related to therapeutic outcomes. More specifically, it sought to understand how Seattle and Bogota differed when it came to this phenomenon, and how these

two different geographical locations informed individualistic and collectivist cultures at large, thus widening the understanding of social support as it relates to different cultures and how findings informed therapeutic outcomes. Based on the literature, Seattle represents an individualist culture and Bogota represents a collectivist culture (Heine, 2008; Hofstede, 1980).

The purpose of incorporating social support into the therapeutic process is to increase the quality and/or quantity of socially derived resources. The incorporation of social support can take many forms, such as administering more measures in therapy (beginning and throughout), encouraging the strengthening of new social networks, and enhancing interactions with existing network members (Rodríguez & Cohen, 1998). Social support groups can serve as another resource that therapists could offer to their clients as another way of seeking social support when none other is available to them (Rodríguez & Cohen, 1998).

Hypothesis and Future Research

We hypothesized that social support from family and friends would be positively correlated with clients' and therapists' perception of therapy progress, and that PSS, therapeutic progress, and therapeutic relationship would differ among cultures. There are several broad aims associated with the hypotheses of the present study: First, this research can promote an increased awareness of the importance of social support integration in therapeutic interventions. Second, the findings may contribute to an increased ability for clinicians to integrate social support interventions. Further, we hope to promote an increased understanding of cultural implications and differences of social support factors in interventions. Lastly, we strive to develop innovative tools for clinicians in order to work toward integrating multicultural social support factors in interventions with diverse populations.

Limitations of Previous Research

While research supports the role of social support in therapeutic outcomes, and the differences in cultural perception and engagement with social support, there is no research to date that explores how cultural differences may impact the relationship between social support and positive therapeutic outcomes (Beckner, Howard, Vella, & Mohr, 2009; LeGrand, 2010; Lourel et al., 2013; Rodríguez & Cohen, 1998; Ogrodniczuk et al., 2002; Silverman, 2014; Waddell & Messeri, 2006; Walker, 2012). This gap in our understanding of these relationships derives from the predominant utilization of social support measures in homogenous experimental research, and low utilization of those same measures in everyday therapeutic interventions where more diverse samples may be available (Lourel et al., 2013; Rodríguez and Cohen, 1998; & LeGrand, 2010.)

CHAPTER II: LITERATURE REVIEW

Van der Kolk (2015) emphasized that feeling safe with people, whether they are friends, family, professionals, or others, is the most important factor in mental health. He argues that safe connections are a fundamental aspect of having satisfying and meaningful lives (Van der Kolk, 2015). Social support refers to the process by which individuals manage the psychological and material resources available through their social networks to enhance their ability to cope with stressful events, meet their social needs, and achieve their goals (Cohen & Hoberman, 1983; Cohen & McKay, 1984; Rodríguez & Cohen, 1998).

Social Support

Kroenke et al. (2013) posit that social support is the web of social relationships that surrounds an individual. Earlier researchers (Cohen & Hoberman, 1983; Cohen & McKay, 1984; Cohen & Wills, 1985) conceptualized social support as the various resources provided by an individual's interpersonal ties which, in turn, act as a mediator of stress. The former definition lacks Kroenke et al.'s (2013) contribution which mentions the help that these relationships provide to the individual's functioning as one of the main aspects of social support. Agrawal, Jacobson, Prescott, and Kendler (2002) argue that social support creates an environment that allows for the individual to feel cared about and valued by others (Chronister, Chou, Frain, & Cardoso, 2008; Kroenke et al., 2013; LeGrand, 2010). Consequently, Murphy, O'Hare, and Wallis (2010) point out that social support is a metaconstruct that incorporates three broad concepts: actual, structural, and perceived social support.

Actual social support is an umbrella term that includes emotional, instrumental, and informational support, and its primary focus is on the frequency and content of social interactions (Murphy et al., 2010). Structural social support is another umbrella term that

comprises community integration and social integration, and that emphasizes looking at how social interactions affect the individual's life as well as the number of people with which an individual has connections, regardless of their nature (Jameel & Shah, 2017; Lustig & Koester, 2010; Murphy et al., 2010) also known as *social embeddedness* (Murphy et al., 2010). Social embeddedness proposes that the higher the quantity of social ties, the greater the social relations with those networks, while a lack of social ties results in social isolation. Community integration and social integration are quite distinct and have unique characteristics (Lustig & Koester, 2010; Murphy et al., 2010). Social integration concerns an individual's social relationships and contact with relatives, romantic partners, friends, co-workers, and strangers (Murphy et al., 2010). Distinct from social integration, community integration, focuses on interactions at the community level (Lustig & Koester, 2010; Murphy et al., 2010). More specifically, this concept refers to the structure of relationships, and is concerned with frequency, homogeneity, and density (King, 1992).

Perceived social support involves an individual's subjective appraisal of that support, and includes the perceived availability of that support, as well as level of satisfaction with the said support (Murphy et al., 2010). Of the three components of social support, according to Murphy et al. (2010), perceived social support is the most functional since it allows for an individual to adapt after an adverse health outcome. Sarason, Sarason, Shearin, and Pierce (1987) claim that perceived social support might be even more important than an individual's actual established relationships. Walker (2012) and other researchers define perceived social support as the resources an individual perceives to be available or that are actually present, from people other than professionals (including clinical providers and specialty care doctors) or from outside of therapy (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Furthermore, perceived social

support not only encompasses the people surrounding the individual, but also is a tool that determines the ability to effectively cope with stressful situations (Lustig & Koester, 2010; Jameel & Shah, 2017; Murphy et al., 2010; Nosheen, Riaz, Malik, Yasmin, & Malik, 2017; & Procidano & Heller, 1983; Sarason et al., 1987).

Murphy et al. (2010) state that the downside to perceived social support is that an individual's interpretations from self-reporting of perceived social support may vary from that of actual received social support. Each of the types of social support (actual, structural, and perceived), while offering unique advantages, lack specific key components. Therefore, each type complements the others in order to fulfill the paradigm and create a more complete model (Lustig & Koester, 2010; Jameel & Shah, 2017; Murphy et al., 2010; Sarason et al., 1987). Consequently, when measuring social support, the measure selected must be comprehensive enough to provide clinicians with a complete framework (Murphy et al., 2010).

Chronister et al. (2008) argue that perceived social support is the most well-researched concept for interpreting the idea of social support, and that it is best demonstrated by its two main roots, a methodological and a theoretical. The methodological root states that data from subjective measures have little in common with data from those of objective measures, which in turn gives birth to two distinct measures: subjective measures of social support and objective measures of social support (Chronister et al., 2008). The theoretical root, conversely, poses that perceived social support is explained in part by one's temperament in response to the quality of one's early primary relationships (Chronister et al., 2008; Lustig & Koester, 2010; Jameel & Shah, 2017; Murphy et al., 2010; Sarason et al., 1987). The dichotomy of these measures has implications for the development of social support interventions, since clinicians must always consider the meaning clients attribute to the social activity (Chronister et al., 2008).

Functions of Social Support

Silverman (2014) argues that social support is a positive factor that facilitates two very important functions: disease recovery and maintenance of health. Both share the factor of functioning as a buffer against the negative effects of stress (Silverman, 2014). Similarly, research by Cohen and Hoberman (1983), Cohen and McKay (1984), Cohen and Wills (1985), Chronister et al. (2008), Kroenke et al. (2013), and LeGrand (2010) also point out the function of social support in mental health, physical health, and emotional health. Additionally, these studies address the way social support positively impacts different cultures and different populations (Cohen et al., 1985; Chronister et al., 2008; Kroenke et al., 2013; LeGrand, 2010; Silverman, 2014; Zeligman, Varney, Grad, & Huffstead, 2018). In an effort to show that social support plays a direct role in treatment initiation, Waddell and Messeri (2006) conducted a study that explored the association between social support, disclosure of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), and the odds of initiating an antiretroviral drug therapy. The results showed that high levels of social support, operationalized as the disclosure of HIV status within family and close friends, improved the odds of the afflicted individual initiating treatment (Waddell & Messeri, 2006). Findings from the studies above suggest that social support clearly fulfills many functions in the realms of emotional, physical, and psychological health.

Mental Health Impacts

Research on stress and coping shows that one of the most effective means by which individuals cope with stressful events is through social support (Cohen et al., 1985; Chronister et al., 2008; Kroenke et al., 2013; LeGrand, 2010; Silverman, 2014). There is substantial evidence showing the benefits of the many forms of social support for both mental and physical health

(Lustig & Koester, 2010; Jameel & Shah, 2017; Murphy et al., 2010; Nosheen et al., 2017; Procidano & Heller, 1983; Taylor et al., 2004). Cohen and Wills (1985) claim that interpersonal relationships act as a buffer against a stressful environment. They call this protective effect the buffering hypothesis, which gave birth to the stress-buffering theoretical model. This model states that social support works by controlling the effects of stress on health and that psychosocial stress has detrimental effects on the health and well-being of those individuals who have minimal social support.

Social support includes the help provided to and available from friends and family, and which facilitates an individual's ability to cope (Ogrodniczuk et al., 2002). While Walker (2012) agrees with Ogrodniczuk et al. (2002), he argues that social support helps in diminishing stress by leading individuals to perceive and understand stressful situations less negatively. Research across disciplines focuses on social support in a variety of populations. Silverman (2014) argues that people with mental illness have smaller social support networks. In contrast, clients with a larger social network manage their mental illness more effectively and remain active in the community. Consequently, these clients experience lower rates of relapse and rehospitalizations (Chronister et al., 2008; Silverman et al., 2014)

Ogrodniczuk et al. (2002) conducted a study on social support as a predictor of grief with 107 outpatient psychiatric clinic patients who were divided into two groups. One group received interpretive group therapy and the other group received supportive group therapy. In the context of this article, interpretive therapy helped to enhance the client's insight about possible behaviors and trauma that are associated with loss (Ogrodniczuk et al., 2002). The therapist used *here and now* experiences to create a sense of tolerance for ambivalence. In supportive therapy, the focus lies more in the problem-solving aspect, the creation for common experiences around praise, and

the quality of external relationships (Ogrodniczuk et al., 2002). The clients were asked to rate their perception of social support using the Multidimensional Scale of Perceived Social Support in the domains of family (e.g., I can talk about my problems with my family), friends (e.g., I can count on my friends when things go wrong), and special person (e.g., There is a special person who is around when I am in need) prior to the start of treatment (Ogrodniczuk et al., 2002). Ogrodniczuk et al. (2002) found that Perceived Social Support (PSS) from friends is associated with positive therapeutic outcomes while PSS from family showed no association. Lastly, when the social support came from a special person, the grief-related symptoms abated significantly (Ogrodniczuk et al., 2002). This study concludes that during periods of grieving, social support assists an individual by fostering better physical health, reducing anxiety, alleviating depression, and lowering use of medications, resulting in an overall better bereavement outcome (Ogrodniczuk et al., 2002). Procidano and Heller (1983) argue that detrimental effects of stressful life events on physical and psychological health raise concerns regarding the validity and effectiveness of therapy alone. They propose that therapy in conjunction with the incorporation and tracking of the client's social support, by the use of measures and screening tools, increases the quality of therapy outcomes.

Van der Kolk (2015) posits that the biological aspects of social support stem from healthy attachments and the social engagement systems, which have their origins in the brain stem. These sympathetic systems allow humans to smile when others smile, nod their heads to show agreement, and frown when they hear upsetting or sad stories. He adds that social support is not limited to merely being in the presence of others; rather, it is social reciprocity – being truly heard and seen by others and feeling important – that truly speaks to this concept. Having a

strong support network of people in life constitutes the most powerful protection against any harmful events, be they physical or emotional (Van der Kolk, 2015).

Developmental Impacts

Social support is an important protective factor that has a significant influence on various groups, one of which is adolescents. Social support is particularly effective in aiding mental health, well-being, and physical health (Glozah & Pevalin, 2017). A study conducted by Glozah and Pevalin (2017) surveyed 770 Ghanaian adolescents who completed a variety of questionnaires, among them the Perceived Social Support friends (PSS-fr) and Perceived Social Support family (PSS-fa) questionnaires, and found that adolescents perceive more support as coming from parents than from friends. Once clients reach age 18, this disparity becomes less marked, with perceptions of equal support from both groups (Glozah & Pevalin, 2017). In addition, those whose parents attained higher education degrees reported higher levels of perceived support from both friends and family than those whose parents did not (Glozah & Pevalin, 2017). They explained that low-income parents are often less involved in their child's life and can offer less support, and that this situation is commonly the result of a low parental level of education.

Social support provides many benefits to the overall health and well-being of older adults. Receiving adequate social support decreases negative long-term health effects when faced with life stressors (Moser, Stuck, Silliman, Ganz, & Clough-Gorr, 2012). Moser et al. (2012) sought to evaluate the psychometric properties of the eight-item modified Medical Outcomes Study Social Support Survey (mMOS-SS). This study combined data from three previous studies for a total of 241 female subjects age 65 and older who had been diagnosed with breast cancer. Results showed that supportive social ties enhance physical and mental health

among older adults by increasing their cancer treatment tolerance, as well as reducing hospitalizations and overall levels of stress (Moser et al., 2012).

Nosheen et al. (2017) examined the moderating role of social support between sense of coherence and mental health outcomes among 200 students from two different cultures and found that social support is very much crucial in academic settings. They articulate that high levels of social support from peers provides a strong buffer against the negative effects of bullying and can help reduce poor academic performance. Family social support also has demonstrated importance in reducing adolescent behavioral and emotional problems (Glozah & Pevalin, 2017; Nosheen et al., 2017; Procidano & Heller, 1983).

Culture

In the field of psychology, culture is a driving factor behind interventions, therapeutic alliance, diagnosis, treatment plans, and research (Hays, 2016). The therapeutic context allows us to make meaningful connections through which we understand the client's identity and create positive therapeutic alliances. In the vein of assessments, taking culture into consideration allows psychologists to conduct culturally responsive assessments, often in the form of utilizing standardized tests in a culturally responsive way, thus leading to culturally appropriate diagnosis. Norcross (2011) posits that in the therapist-client relationship culture impacts not only the client's identity and how psychologist chose to apply interventions, it considers the therapy format, the clinical setting, and the influence the content and process of therapy.

Over the course of his studies on cultural differences, Hofstede concluded that people are born with mental programs, referred to as *softwares of the mind,* which are developed by the culture that surrounds the individual during childhood (Hofstede, 1980; Hofstede, 2011). Hofstede's famous 2011 study surveyed 100,000 International Business Machines (IBM)

employees in 71 countries and entailed creating five categories or dimensions to characterize

dominant cultural patterns. In 1980, Hofstede coined the five major categories within the culture

concept: power distance, uncertainty avoidance, individualism versus collectivism, masculinity

versus femininity, and time orientation. These five categories also provide an insight into

relationships between cultural values and social conducts. Building on this research, House et al.

(2004) created the Global Leadership and Organizational Behavior Effectiveness (GLOBE)

project. House et al. (2004) added five more dimensions to Hofstede's model: gender

egalitarianism, assertiveness, performance orientation, future orientation, and humane orientation

(House et al., 2004). They broke down the individualism versus collectivism dimension further

into two components: ingroup collectivism (the degree to which people express pride, loyalty,

and cohesiveness in their families) and institutional collectivism (the degree to which a culture

encourages collective distribution of resources and collective actions).

Individualism and Collectivism

Collectivist and individualist values differ mainly on their focus of the collective self

versus the personal self. Hofstede defines culture as the collective programming of the mind –

based on beliefs, values, and environmental factors – which distinguishes the members of one

human group from another (Hofstede,1980; Hofstede, 2011). One way of characterizing and

conceptualizing culture is to divide it into two major subgroups: collectivist cultures and

individualist cultures. Heine (2008) explains that individualist cultures usually encourage

individuals to prioritize their own personal goals rather than the goals of the group, while the

reverse is true in collectivist cultures (Heine, 2008). Members of individualistic cultures are

more likely to behave independently since the goal is to feel and be distinct from others. This is

achieved when one becomes self-sufficient. Meanwhile, in collectivistic cultures the self is

considered an interdependent self and individuals are encouraged to put more emphasis on the group's goals. Close relationships and maximizing the wellbeing of the individuals that make part of the larger community are the most important priorities in a collectivistic culture. Relative to the study delineated in this dissertation, Hofstede (1980) surveyed 50 countries, among which were Colombia and the United States, and determined that Colombia had a low degree of individualism and a high degree of collectivism, while the United States had a high degree of individualism and a low degree of collectivism (Hofstede, 1980; Heine, 2008).

Another way to characterize cultures is by communication practices. Hall (1989) organizes culture by the setting and context in which communication takes place, as well as by the amount of information implied in the communication. He found that often communication does not rely on the actual words that are spoken and that instead it relies on the role of context. Hall created a taxonomy titled *High and Low Context Cultures,* which stems from the idea that some cultures naturally use high-context messages, others low-context messages, while still others use a mix of both (Hall, 1989). These characteristics include the use of direct or indirect messages, culture's orientation to time, and the importance of ingroups and outgroups (Hall, 1989). East Asian and South American cultures are representative examples of high-context cultures, whereas North American and English-speaking cultures more generally are low-context cultures (Heine, 2008). A question in Japan such as, "Is it okay if I park my car here?" might be answered with a pause, a strained look on the face, and only the words "Well, a little." A pause and a strained look on someone's face sends a signal that is clear to a native Japanese speaker that is not okay to park there. The key information is conveyed nonverbally, with the content of the words being rather empty (Heine, 208). In low-context cultures there is less involvement among individuals and therefore, it is necessary for people to communicate in more explicit

detail (Heine, 2008).

      Collectivist cultures. Certain cultures are characterized as collectivist because they emphasize collective goals (Heine, 2008; Hofstede,1980; Hofstede, 2011; Lustig & Koester, 2010; Tjosvold, Law, & Sun, 2003). Collectivism, as a construct, includes practices such as cooperative goals; family-driven educational goals and careers; and arranged marriages. In addition, other traits include promoting school children from one class together to the next grade; compensating employees based on seniority and loyalty to the company; and extended families living under one roof (Heine, 2008). Heine (2008) posits that collectivist cultures believe family is the most important aspect of an individual's life. Moreover, family is often at the center of a person's social circle, and the family is involved in that individual's life at every milestone (Heine, 2008). Elaborating on this point, Heine claims family not only encompasses the nuclear family idea the United States holds, but also, the concept of an extended family that can offer support and can be more cohesive, allowing for members to be very healthy emotionally as a result (2008). Often, the nuclear family in one household will have close relationships with members of the extended family, which increases the social support an individual receives.

      One country that represents typical collectivist cultural values is Colombia, located in South America and home to approximately 50,000,000 habitants. At the heart of Colombia lies Bogota, the capital city and largest metropolitan area. Colombia's modern population and culture are the result of the Spanish conquest, with a primarily Roman Catholic, *mestizo* (a mix between European and Native Indian descent), and other combinations such as those from African and European populations (Kline & Garavito, 2018).

      Citizens of Bogota will often prioritize maintaining the harmony of relationships by avoiding conflict for the reason of protecting social face (Tjosvold et al., 2003). They are known

for the quality of their long-lasting relationships and the firm boundaries they create around distinctions between outsiders and insiders (Costalas, 2009). In addition, they possess a higher level of uncertainty avoidance, meaning they are rigid and controlled, Therefore, making them less flexible to situations involving sudden change.

Greetings in this culture are lengthy and open-ended, and often include questions around meals of the day (Costalas, 2009). When someone needs help, Colombians will not necessarily see it as an opportunity to teach the individual, but instead as an opportunity to solve the immediate need. They also structure their time around other people instead of schedules, valuing past and present events, as well as continuity, over future events, with the completion of tasks held as less important than the value of working together (Costalas, 2009).

Individualist cultures. The United States is the fourth-largest country in the world with a population of approximately 325,000,000 out of which 75.6% are Anglo American (*Worldmark Encyclopedia of the States*, 2018). Seattle, Washington is an example of a diverse American city and has a mixture of cultures, religions, and ethnicities (*Worldmark Encyclopedia of the States*, 2018).

Seattle is characterized as an individualist culture because of the nature of its habitants' less clearly identified boundaries between insiders and outsiders, more acceptance of cultural change, more priority placed on work compared to friendships, and their efficient management of time (Costalas, 2009). People from Seattle will often have conversations around noncontroversial topics with strangers, such as sports, weather, and jobs, almost never divulging topics they consider personal, unlike their collectivist counterparts (Costalas, 2009). Their greetings are kept to a minimum and are closed-ended. In addition, they try to support their facts with evidence, and experience is perceived as less important. They have a strong sense of

ownership, especially around their personal space; when it comes to helping others, it is much more about helping themselves feel better or improve in some way; their communication style is direct and they prefer honesty above everything, although this trait is less pronounced compared to individuals living on the American East Coast than in the West Coast since Seattleites are considered evasive and indirect; and they are more accepting of the future and encourage change **(**Costalas, 2009).

Some practices common in individualistic cultures include promoting children individually to the next school grade based on capabilities instead of promoting children as a cohort; encouraging college-aged individuals to move out of their parent's home instead of allowing them to stay through college; setting wages based on merit in the workplace instead of performance as a group; giving employees individual offices or cubicles instead of rooms where social interaction is more common; and choosing to put their elderly relatives in retirement homes instead of taking care of them in the family home (Heine, 2008).

Social Support and Culture

Culture impacts the conceptualization of social support (Costalas, 2009; De Mooij & Hofstede, 2010; Hays, 2016; Heine, 2008; Hofstede,1980, 2011; Lourel et al., 2013; Tjosvold et al., 2003; Sacco, Casado, & Unick, 2011). In turn, social support can impact the way individuals cope with stress and can provide benefits for physical health within and across cultures (Heine, 2008; Nosheen et al., 2017). Individuals in Western Europe and North America tend to be encouraged to focus on distinctiveness and often act according to their own volition (Lustig & Koester, 2010). In other words, they tend to view themselves as individuals, independent and separate from other people. In East Asia, where most cultures are collectivistic, by contrast, individuals are encouraged to focus on their relationships and act in accordance with the group in

order to maintain harmony (Heine, 2008; Nosheen et al., 2017). Here, people are thought of more as fundamentally connected with others (Lustig & Koester, 2010; Nosheen et al., 2017; Taylor et al., 2004). These differences affect how and whether individuals seek and use social support.

The Eastern cultural philosophy about relationships might lead to the assumption that coping with stressful situations by using social networks and social support might be fairly common. These cultural differences also attribute various meanings to social support. The idea that social support is defined as a person seeking help from another person in service of their problems is solely a Western definition (Lustig & Koester, 2010).

Culture and Mental Health Treatment

Heine (2008) argues that culture can shape the way individuals react and interpret the effects and various aspects of mental health. In individualist cultures it is very common to seek out professional help when struggling emotionally (Lustig & Koester, 2010; Hays, 2016; Heine, 2008). In collectivistic cultures, there may be a stigma associated with acknowledging that a problem exists, and even more so when considering the notion of seeking help outside of the family (Lustig & Koester, 2010; Hays, 2016; Heine, 2008). Most often this happens because, culturally speaking, individual feelings should not be the focus of attention at any given time (Lustig & Koester, 2010; Hays, 2016; Heine, 2008). Based on this, it is safe to say that culture affects the success of treatment.

In 1997, Cohen introduced the Direct (or Main) Effect Model of stress as a tool to conceptualize social support as the idea that being involved in a social network and having quality social support positively affects health outcome no matter the stress level (Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997; Cohen, Gottlieb, & Underwood, 2000). A study by

Hashimoto, Kurita, Haratani, Fujii, & Ishibashi (1999) found that older adults living in Tokyo (a collectivist culture) with high levels of social support were less depressed than those with poor social support before significant life events that were considered stressful. These findings might be due to having access to a larger source of support, which in turn helps improve health by having positive psychological responses resulting from network participation; or a supportive environment around the individual (Cohen et al., 1997; Cohen et al., 2000; and Hashimoto et al., 1999).

The Impact of Relational Differences

It has become increasingly important that therapists obtain multicultural competence in the field of psychology (Hays, 2016). Hays introduced the ADDRESSING model; an acronym which stands for Age and generational influences, Developmental or other Disability, Religion and spiritual orientation, Ethnical and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and finally, Gender. This is used as an assessment tool to bring to the forefront all important cultural variables between therapist and client, and in this way find the best fit when selecting therapeutic interventions and developing strong therapeutic alliances (Hays, 2016; Norcross, 2011; Northey, 2011).

Hays (2016) argues that one of the most powerful tools a therapist can offer a client is the ability to reengage with individuals or groups outside of therapy who have been of positive influence in the past, who have brought happiness, and who have motivated the client in a positive way. In addition, Hays explains that this tool is so beneficial because the client most likely will turn to something with a cultural tie, which will enhance the chances of making that behavior stick (Hays, 2016).

Many studies have explored therapy outcomes and the different variables that play into

them (Beckner et al., 2009; Dindinger, 2012; Norcross, 2011; Silverman, 2014;). Research shows that 75% of those who enter treatment exhibit some improvement, with the exception of some cases involving severe disorders like bipolar and the schizophrenias, for which medication is the primary treatment (Norcross, 2011). It is important to talk about the negative effects of therapy as well, and to recognize that 5% to 10% of clients leave therapy in worse conditions than when they started (Norcross, 2011). Both negative and positive outcomes depend largely on the client, but are also affected by the therapist (Norcross, 2011). Individuals' negative experiences in psychotherapy are mostly attributed to the relationship they have with their therapist (Norcross, 2011). Recently, clinical practice has started to incorporate a way of tracking client treatment outcomes based on responses using standardized scales throughout the course of treatment, which can guide the therapist in modifying the therapy accordingly (Norcross, 2011). Research has also demonstrated that social support and therapy outcomes influence each other positively (Beckner et al., 2009; Dindinger, 2012; Norcross, 2011; Silverman, 2014). Beckner et al. (2009) illustrate that the relationship of social support to outcome might vary depending on the approach to treatment the psychologist chooses.

Ever since the incorporation and utilization of patient tracking progress and success rates, it has been a challenge to find the *best fit* outcomes measure that encompasses all the different aspects psychologists study. Research shows that a single tool should not be selected to measure multiple variables and that fit of modality, personality, and the impact of multiple interventions all factored into this decision (Caldwell, Twelvetree, & Cox, 2015). Another issue researchers have raised is at what point in the therapy process is it appropriate to start evaluating outcomes.

Therapy Outcomes

Northey (2011) found four common factors that influence the predictors for therapeutic outcomes. These were client variables; the client-therapist relationship; theoretical perspectives and therapeutic techniques; and expectancy factors (Northey, 2011). Of these four factors, client variables and the client-therapist relationship prove to be the most influential, and are most closely associated with successful therapy outcomes (Northey, 2011). The quality of the alliance formed between client and therapist correlates to increased client therapy attendance. Consequently, a client's alliance with friends and family might predict the likelihood of continuing therapy (Northey, 2011). Norcross (2011) argues that the relationship between therapist and client significantly affects therapy outcomes, no matter which theoretical model or treatment modality the therapist utilizes. Silverman (2014), Beckner et al. (2010), and a variety of other recognized figures in the field of social support research field agree with Norcross in that social support and therapy outcomes are positively correlated. Perceived social support and trust have been linked and can lead to long-term successful therapeutic outcomes (Beckner et al., 2010; LeGrand, 2010; Leibert, 2006; Lourel et al., 2013; Rodríguez & Cohen, 1998; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014; Waddell & Messeri, 2006; Walker, 2012). Beckner et al. (2009) found that the relationship of social support to outcome might vary depending on the approach to the treatment chosen. Vasquez, Bingham, & Barnett (2008) agree with Beckner et al. (2009) and additionally found that while therapy has proven successful in many occasions and clients have been able to achieve their goals, this is not always the case, given that 30% to 57% of clients seeking psychotherapy drop out of treatment prematurely. The root cause for premature termination has been significantly correlated to poor quality therapeutic relationships (Vasquez et al., 2008). Consequently, social support outside of therapy, which leads to a positive and secure relationship with the therapist, leads to successful therapeutic

outcomes and decreases the premature termination of therapy (Beckner et al., 2010; LeGrand, 2010; Lourel et al., 2013; Rodríguez & Cohen, 1998; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014; Waddell & Messeri, 2006; Vasquez et al., 2008; Walker, 2012). Based on the Common Factors Model, four elements are present when studying therapeutic outcomes: extratherapeutic factors, models and techniques, therapist, and therapeutic relationships (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011). Therefore, this study explores client's perception of the therapeutic relationship and therapy progress, as well as the therapist's perception of the therapeutic relationship and progress.

Therapeutic Alliance

Another important aspect to consider when assessing social support is therapy attendance. Northey (2011) argues that positive relationships between clients and therapists predict client attendance. Hays (2016) ventures further to say that respect, communication, human connection, therapist self-disclosure, and ethical boundaries are all part of creating a successful and strong therapeutic alliance. Additionally, Hays makes the case for other variables that may also impact the alliance such as nonverbal communication, environmental cues, time management, and countertransference (2016).

Mallinckrodt (1996) conducted a study with 70 university students that were engaged in psychotherapy. The goal was to examine the relationships among the client working alliance, Perceived Social Support (PSS), and psychological symptoms. This study only retained participants who completed a minimum of eight sessions, which shows that rapport and progress can potentially be established by the eighth session (Mallinckrodt, 1996). Research shows that 29% to 38% of clients improve after one to three psychotherapy sessions, 48% to 58% improve after four to seven sessions, and 56% to 68% improve after eight to sixteen sessions. Therefore,

the therapeutic relationship is correlated with positive therapeutic outcomes (Beckner et al., 2010; LeGrand, 2010; Lourel et al., 2013; Mallinckrodt, 1996; Rodríguez & Cohen, 1998; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014; Waddell & Messeri, 2006; Vasquez et al., 2008; Walker, 2012).

Social Support Measures for Therapy

Social support as a concept is often measured through screeners where the therapist has access to data and tracks their client's social support throughout the treatment. This knowledge can be useful for interventions and recommendations. The most prominent social support questionnaires and measuring tools are discussed below in order to provide information about existent assessment tools and to provide context for the necessity of development of additional measures.

The Social Support Questionnaire (SSQ) was created by Sarason et al. in 1983. It is a 27-item questionnaire with two parts. The first part of each item assesses the number of people available to the responder (person taking the questionnaire) in times of need. The second part measures the degree of satisfaction with these relationships and their equivalent support (Sarason et al., 1987).

The Interpersonal Support Evaluation List–12 (ISEL-12) was developed by Cohen et al., (1985) to study associations between social support and health. It is a 12-item questionnaire with a four-point Likert scale and it contains three subscales (four items each): *Tangible*, defined as the perception that one can get material aid; *Belonging*, defined as the availability of individuals with whom to share activities; and *Appraisal*, defined as the perceived ability to talk about one's problems (Sacco et al., 2011). The downside to this measure is that it does not provide the ability to separate out from whom the social support comes and is therefore, not comprehensive.

It is important to understand the difference between support from friends as opposed to support from family. Different populations, especially different age cohorts, rely on these supports in different ways (Procidano & Heller, 1983). Consequently, these relationships may shift at specific time to relying more on family or more on friends. Friend relationships are often of short duration while family relationships are commonly thought of as long-term relationships (Glozah & Pevalin, 2017; Procidano & Heller, 1983). Perceived Social Support from friends (PSS-Fr) explores the type of relationships the clients have with their friends. This measure looks more in depth as to whether friends fulfill needs such as support, information, and feedback (Glozah & Pevalin, 2017; Procidano & Heller, 1983). Perceived Social Support from family (PSS-Fa) explores the type of relationships clients have with their family members. Additionally, it focuses on the extent to which an individual perceives that needs for support, information, and feedback are fulfilled by family members (Glozah & Pevalin, 2017; Procidano & Heller, 1983). The present study utilized the PSS-fr and PSS-fa as tools to measure social support because they have been validated for both English and Spanish speaking populations and because they differentiate support from families and friends. The psychometric properties and utility are detailed in Chapter III.

Inventory of Socially Supportive Behaviors (ISSB) was created by Gangemi, Faraci, Menna, & Mancini (2010) who found that Procidano and Heller's (1983) measure did not capture specific behaviors. Therefore, in 1981 they created another measure to address this issue by increasing the behavioral specificity of the rating process. This measure consists of 40 items that evaluate the quality of the social support received (receiving being the specific behavior) in the previous 30 days (Gangemi et al., 2010).

CHAPTER III: METHODOLOGY

This chapter presents the study methodology, including design, procedures, population, sample, survey instruments, and the research questions and hypotheses. Additionally, it explains rationale and implementation of study methods.

Sample and Inclusion Criteria

The sample was comprised of 39 individuals from Bogota, including six therapist participants and 33 client participants, and 32 individuals from Seattle, with five therapist participants and 27 client participants. Client participants were adults who lived in Seattle or in Bogota, who had participated in a minimum of eight sessions of therapy at the time of participation, and who were currently engaged in individual therapy. This criterion was derived from previous studies exploring therapy outcomes that have required study participants to attend eight to sixteen sessions to be eligible (Mohr, Classen, & Barrera, 2004; Ogrodniczuk et al., 2002; Thrasher, Power, Moran, Marks, & Dalgleish, 2010). For a CBT protocol (Beck, 1979; Beck & Beck, 2011), anywhere from ten to twenty sessions, or three to four months, gives the clinician enough time to implement an intervention and obtain outcomes.

Because the focus of the research addressed differences between two cultures, samples from Bogota and Seattle included only Hispanic/Latinx or Anglo-American/European individuals, respectively. This was done in an effort to preserve the integrity of the samples relative to the cultural differences between individualist and collectivist cultures. This also means that those from other cultures were not eligible for participation.

Individuals with diagnoses of schizophrenia, developmental disabilities, active psychosis, or current crisis were excluded from the sample. The clients who participated endorsed a variety of mental health symptoms. These were: sadness; hopelessness; restlessness; irritability; loss of

interest; trouble concentrating; trouble making simple decisions; fear; worry; avoiding situations because of difficult emotions; thoughts of death or suicide; difficulty concentrating; trouble sleeping; muscle pains; thoughts, feelings, or behaviors that interfere with daily activities; performing repetitive behaviors; sweating more than normal; feeling shaky; increased heart rate; scared of dying; scared; nightmares; feeling on guard; easily startled; stress across settings; tearful; overwhelmed; or any combination thereof. We chose to include the aforementioned psychological concerns due to commonality, in order to have consistency across the Seattle and Bogota samples, and in an effort to increase the size of the sample.

Survey Instruments

The study incorporated two demographic questionnaires (See Appendix B), two social support measures (See Appendix B), and a researcher-made Session-Alliance-Approach (SAA) rating scale (See Appendix B). The social support measures chosen were Perceived Social Support measure from friends (PSS-fr) and Perceived Social Support measure from family (PSS-fa;r). We received permission from Dr. Procidano and Dr. Domínguez Espinosa, authors of the English and Spanish versions of the PSS-fa and PSS-fr, to use the Spanish translated version of the PSS-fa and PSS-fr as well as the English versions (See Appendix B for survey items, and Appendix D for copyright permissions).

The study had two demographic questionnaires, one for client participants and one for therapist participants. The client demographic questionnaire was used to obtain basic demographic information including age, sex, race/ethnicity, nationality, highest level of education achieved, relationship status, occupation, employment status, and composition of household. Additionally, at the end of the demographic questionnaire there were two questions; one regarding the clients' perceived therapeutic progress and one regarding perceived therapeutic

relationship between the client and their therapist.

The purpose of the demographic questionnaire given to the therapists was to capture each of their client's diagnoses, the symptoms the clients endorsed, the intervention used with each client, theoretical orientation, and the number of sessions they had with each of their clients. Additionally, at the end of each demographic questionnaire there were two questions: one regarding the therapist's perception of therapeutic progress the client had made and one regarding the therapist's perception of the therapeutic relationship with their client.

The study also included an author-created measure named the Session-Alliance-Approach (SAA) rating scale. This measure evaluates the client's perception of the relationship with their therapist, their feelings about the session, and the level of usefulness of the coping mechanisms they were taught in therapy. The measure had a total of 12 items which were rated on a 5-point Likert-like scale from one (strongly disagree) to five (strongly agree). Item 12 was reverse-scored, where a score of one meant strongly agree and a score of five meant strongly disagree.

The social support measures used in this study were the Perceived Social Support from family (PSS-fa) and Perceived Social Support from friends (PSS-fr). Both of these questionnaires explored the type of relationships clients have with their families and friends and whether needs such as support, information, and feedback were fulfilled by friends and family (Procidano & Heller, 1983). For these measures, friend relationships are often of short duration while family relationships are commonly conceptualized as long-term relationships. Sample items from the PSS-fr and PSS-fa included: "*I rely on my friends for emotional support*" and "*Members of my family are good at helping me solve problems*," respectively. The English language version had 20 items on each scale and it consisted of 20 statements. The PSS-fa and

PSS-fr scales have been professionally translated into Spanish and contain 16 and 12 items, respectively (Domínguez, Salas, Contreras, & Procidano, 2011). For the English and Spanish versions, individuals had three response options: "Yes," "No," and "Don't know." For each item the "Yes" response was scored as a 1 and the "No" answers were scored as 0. The "Don't know" category was not scored. In the English language versions, the PSS-fa, items 3, 4, 16, 19, and 20 are scored inversely, attributing 1 to "No" and 0 to "Yes" (Procidano & Heller, 1983). In the PSS-fr, items 2, 6, 7, 15, 18, and 20 were scored inversely attributing 1 to "No" and 0 to "Yes" (Procidano & Heller, 1983). In the Spanish versions, the PSS-fa the items 3 and 4 were scored inversely attributing 1 to "No" and 0 to "Yes" and in the PSS-fr the items 2, 5, 11, and 12 were also scored inversely (Domínguez Espinosa, Menotti, Bravo, & Procidano, 2011; Domínguez Espinosa & Bravo, 2010). Scores ranged from 0, which indicated no perceived social support, to 20, which indicated maximum perceived social support as provided by friends and family. A Cronbach's alpha of .88 and .90, internal consistency between .83 and .86 reliability, and construct validity have been attributed to these scales (Procidano & Heller, 1983). To preserve the validity and integrity of these tests, we decided to keep the measures as they are (not making them the same number of items) since they are comparable based on the Rasch model (Domínguez Espinosa, Menotti, Bravo, & Procidano, 2011; Domínguez Espinosa & Bravo, 2010). The Rasch Model is a psychometric tool for analyzing categorical data, such as questionnaire responses as a function of the trade-off between the respondent's attitudes, abilities, or personality traits, and the item difficulty (Rasch Model, 2017). Shortening the scales does not affect the validity of the measures (Rasch Model, 2017). The Rasch model uses the Rasch analysis which is a unique approach of mathematical modeling based upon a latent trait and accomplishes a probabilistic measurement of persons and items on the same scale.

Consequently, the Spanish scales are unidimensional and the variance for each scale corresponds to 48.5% for the PSS-fa and a 39.6% for the PSS-fr.

Design and Procedure

Clients and therapists were surveyed from two counseling centers; one in Seattle, WA and the other one in Bogota, Colombia. Client participants were actively enrolled in therapy and had completed a minimum of eight therapy sessions at the time of their participation.

The clients were introduced to the study by their therapists either while in session or through a flyer that was posted at each site (See Appendix A). Participants completed a consent form (See Appendix A) prior to filling out the questionnaires. Questionnaires were given in a pencil and paper format. Clients were given the option of completing the questionnaires independently in the waiting room or during session with their therapist, but they were not allowed to take questionnaires outside the clinic. After clients filled out the questionnaires the therapists debriefed them and provided a list of local mental health resources, including information on social support groups and other ways of increasing social connectivity (See Appendix C). Clients were instructed to take their questionnaires to the front desk, and all document were housed in a HIPAA compliant and secure manner. Questionnaires required approximately ten minutes for each client and five minutes for each therapist.

As an incentive, therapist and client participants were given a gift card for their participation. Specifically, client participants were given gift cards for a local coffee shop and therapist participants received a gift card with amounts based on the quantity of clients on their case load that participated.

CHAPTER IV: RESULTS

We sought to investigate relationships across and differences between Perceived Social Support (PSS), perceived therapeutic relationship, and perceived therapy progress in different cultures. We explored cultural perceptions, utilizations, and functions of social support, particularly between individualist and collectivist cultures, Seattle and Bogota respectively. Specifically, we compared psychotherapy clients in Seattle and Bogota on perceived social support and client ratings of various aspects of the quality and effects of therapy. In addition, we also incorporated therapist's perceptions of therapy progress and alliance and compared these data between Bogota and Seattle. Lastly, we sought to look at the relationship of social support and client's perceptions of therapeutic progress and alliance. This chapter describes the study's participants, descriptive statistics, assumptions, research questions, and results of statistical analyses.

Sample Characteristics

This study used a quantitative correlational non-experimental cross-sectional analysis. It included a nonrandom approach studying two non-equivalent groups. Data collected was analyzed using Statistical Package for Social Sciences (SPSS) version 25.0 for Windows. A total of 65 clients participated in this study; 31 from Seattle and 35 from Bogota. However, three client participants were eliminated due to having incomplete data and two participants were excluded from the Seattle sample, ending in a total client sample of 60. In addition, 11 therapists participated; five from Seattle and six from Bogota. Each therapist had between one and fifteen clients that participated in the study. All of the therapists had at least a Masters degree. The few that had a PsyD degree were from the Seattle sample.

As seen in Table 1, 63% were female (*n* = *38*) and 37% were male (*n* = 21). The average

age of participants was 33 years old (*Mdn* = 29.00*).* The Seattle sample was entirely Caucasian,

while the vast majority of the Bogota sample identified as Latino (*n* = 32). At the time of data

collection, 13.3% lived alone, 10% lived with only spouses/partners, 5% lived only with

children, 2.2% lived only with siblings, and 5% lived with only a roommate. Most participants

(61.8%) reported they lived with more than one household member.

Table 1

Demographics

	Total (N = 60)		Bogota (n= 33)		Seattle (n = 30)	
	Frequency	%	Frequency	%	Frequency	%
<u>Sex</u>						
Female	38	63.3	19	57.6	19	70.4
Male	21	35.0	13	39.4	8	29.6
Missing	1	1.7	1	3	0	0
<u>Race</u>						
Caucasian	27	45	0	0	27	100
Latino	30	50	30	90.9	0	0
Mulato	1	1.7	1	3	0	0
Trigueno	1	1.7	1	3	0	0
Missing	1	1.7	1	3	0	0
<u>Education Level</u>						
High school graduate, diploma or the equivalent (GED)	8	13.3	6	18.2	2	7.4
Some college, no degree	7	11.7	0	0	7	25.9

Trade/technical/ vocational training	11	18.3	7	21.2	4	14.8
Associates	4	6.7	0	0	4	14.8
Bachelor's Degree	21	35	14	42.4	7	25.9
Master's Degree	9	15	6	18.2	3	11.1
Relationship Status						
Single	29	48.3	20	60.6	9	33.3
Partnered	8	13.3	3	9.1	5	18.5
Married	18	30	7	21.2	11	40.7
Divorced	4	6.7	2	6.1	2	7.4
Widowed	1	1.7	1	3	0	0
Occupation						
Employed	26	43.3	7	21.2	19	70.4
Employed and Independent	1	1.7	0	0	1	3.7
Employed and student	2	3.3	0	0	2	7.4
Independent/Self-employed	9	15	8	24.2	1	3.7
Independent/Self-employed and stay at home	1	1.7	1	3	0	0
Retired	1	1.7	1	3	0	0
Student	11	18.3	11	33.3	0	0
Student and Independent/self-employed	1	1.7	1	3	0	0
Stay at home	7	11.7	4	12.1	3	11.1
Unemployed	1	1.7	0	0	1	3.7
Employment Status						
Full-time	28	46.7	10	30.3	18	66.7

Part-time	11	18.3	6	18.2	5	18.5
Unemployed/student	18	30	15	45.5	3	11.1
Missing	3	5	2	6.1	1	3.7

Descriptive Statistics of Social Support, Outcomes, and Alliance

As shown in Table 2, participants perceived social support from both family and friends on about half of the items. In contrast, perceptions of outcomes and alliance were all very high. Clients were asked about their perceived therapy progress and alliance on a one to six scale, but all had such extreme positive ratings that all but one were rated five or six. Clients also rated the Session-Alliance Approach very highly. While therapists used the full scale for ratings of progress and alliance, their responses also had negative skews with most responding very positively, especially in the case of rating their alliance with the client.

Perceived Social Support

This variable was analyzed obtaining a percentage and it was mostly skewed towards positively rating support from friends. Other scales, such as the clients and therapists' perceptions of progress and alliance were measured as averages across number of items (Likert scale of six items)

Session-Alliance-Approach

The Session-Alliance-Approach (SAA) rating scale measure was an author created measure never used before. Originally, it had 12 items and its Cronbach's Alpha was .73. After data collection and upon further analysis, item 10 '*The therapist was friendly*' was removed due to it lacking variability among participants. Item 12 '*I felt there was something missing in this therapy*' was also removed because it was the only reverse coded one and was included at the end of the questionnaire which made it difficult for people to keep focus and answer correctly.

Item 7 *'This therapy and the skills that I have acquired helped me deal more effectively with my problems'* was also dropped since the alpha would be higher and upon further analysis it was found that this item was the only one that focused more on therapy outcomes. In addition, it was not measuring the same thing as the other items. After removing these items, Cronbach's Alpha was increased to .82. See Tables 2 and 3 for more detail.

Table 2

Bogota Questionnaire Descriptive Statistics

Scale	Mean	Median	SD	Min	Max	Skewness (*SE=.30-.44)*
PSS-family	.58	.56	.28	.13	1	-.04
PSS-friends	.54	.58	.30	0	1	-.50
Client's perceived therapy progress	5.58	6	.56	4	6	-.93
Client's perceived therapeutic alliance	5.84	6	.37	5	6	-1.93
Session-alliance-approach (SAA) rating scale	4.90	5	.22	3.89	5	-3.56
Therapist's perceived therapy progress	4.53	4.5	1.16	1	6	-.93
Therapist's perceived therapeutic alliance	5.5	6	1.13	1	6	-3.09

Table 3

Seattle Questionnaire Descriptive Statistics

Scale	Mean	Median	SD	Min	Max	Skewness (*SE=.44)*

PSS-fa	.52	.5	.24	0	1	-.16
PSS-fr	.65	.8	.30	.05	1	-.80
Client's perceived therapy progress	5.67	6	.55	4	6	-1.46
Client's perceived therapeutic alliance	5.96	6	.19	5	6	-5.196
Session-alliance-approach (SAA) rating scale	4.91	5	.14	4.33	5	-2.599
Therapist's perceived therapy progress	4.96	5	.80	3	6	-.40
Therapist's perceived therapeutic alliance	5.37	6	.74	4	6	-.73

Distribution of Data

The skewness statistics and inspection of the distribution of the responses indicate that all the scales except the PSS-family were not normally distributed. There were also some extreme outliers on scales due to the majority of participants using small ranges of the scales such as four to six (with the majority being fives and sixes) on Likert scales that ranged one to six. Other scales had two or three points used and this made them more like ordinal or categorical variables rather than quantitative variables; some were recoded to reflect groups and will be discussed when applicable in the hypothesis testing below. Consequently, assumptions of parametric tests were violated and non-parametric tests were used; for consistency this was done even for PSS-family, which was close to a normal distribution, as most hypothesis included both PSS-family and PSS-friends, and the latter was negatively skewed and required non-parametric tests. Crosstabulation with chi-square test of independence or Fisher's exact test, Wilcoxon signed-rank tests, and Mann Whitney U tests were used as applicable to address each of the research questions listed below. An alpha level of 0.05 was used for all tests.

Hypothesis Testing

Research Question 1: Does Perceived Social Support (PSS) Differ Between Individualist and Collectivist Cultures?

PSS was measured by obtaining percentages. As noted, while PSS-family was somewhat normally distributed, PSS-friends was negatively skewed and for consistency the differences between Seattle and Bogota on both scales were thus examined using the non-parametric Mann-Whitney U test.

Alt. H1.1: There is a significant difference between Seattle client's PSS-family and Bogota client's PSS-family.

Scores on the PSS-family were not significantly different between Seattle ($n = 27$, $Mdn = .5$) and Bogota ($n = 33$, $Mdn = .56$), $U = 400.0$, $p = .498$. Therefore, the null hypothesis was retained.

Alt. H1.2: There is a significant difference between Seattle client's PSS-friends and Bogota client's PSS-friends.

Scores on the PSS-friends were not significantly different between Seattle ($Mdn = .8$) and Bogota ($Mdn = .58$), $U = 334.5$, $p = .098$. Therefore, the null hypothesis was retained.

Research Question 2: Does Client's Perceived Therapeutic Progress Differ Between Bogota and Seattle?

Therapy progress was measured on a six-point scale but most people rated their progress as six, with small numbers using five and only two using four. Thus, this variable was not only extremely skewed, it was, in a practical sense, categorical and thus divided into two groups: strong progress (6) and less than strong progress (4 or 5). A chi-square test of independence was used to compare this binary representation of therapy progress to city.

Alt. H2.1: There is a significant difference between Bogota and Seattle on the client's perception of therapy progress.

Scores on client's perception of therapy progress did not significantly differ between Bogota (strong progress group 57.6% and less than strong progress group 36.4%, *Mdn* = 6) and Seattle (strong progress group 70.4% and less than strong progress group 29.6%, *Mdn* = 6), $\chi^2(1)$ = .527, *p* = .468. Therefore, the null hypothesis was retained.

Research Question 3: Does Perceived Social Support Differ Between Family and Friends?

A Wilcoxon signed-rank test was used to compare individuals' scores on PSS of family and PSS of friends. This is the non-parametric equivalent to a paired sample t-test that compares two measures using the same scale – in this case, family and friends.

Alt. H3.1: There is a significant difference between PSS-family and PSS-friends.

Scores on the PSS-family (*Mdn* = .56) and PSS-friends (*Mdn* = .66) were not significantly different, *Z* = -.67, *p* = .499. Therefore, the null hypothesis was retained.

Research Question 4: Is There a Relationship Between PSS and Therapy Progress?

To examine this research question a Mann-Whitney U test was used with the two groups of therapy progress as the independent variable and PSS as the dependent variable.

Alt. H4.1: There is a significant relationship between Bogota client's PSS-family and Bogota client's rating of perceived therapy progress.

Client's PSS-family did not significantly differ depending on the client's rating of perceived therapy progress (strong progress group 57.6% and less than strong progress group 36.4%, *Mdn* = 6) in the Bogota sample, *U* = 110.0, *p* = .870. Therefore, the null hypothesis was retained.

Alt. H4.2: There is a significant relationship between Bogota client's PSS-friends and Bogota client's rating of perceived therapy progress.

Client's PSS-friends did not differ significantly on client's rating of perceived therapy progress (strong progress group 57.6% and less than strong progress group 36.4%, *Mdn* = 6) in the Bogota sample, *U* = 88.0, *p* = .288. Therefore, the null hypothesis was retained.

Alt. H4.3: There is a significant relationship between Seattle client's PSS-family and Seattle client's rating of perceived therapy progress.

Scores on the client's PSS-family did not significantly differ by client's rating of perceived therapy progress (strong progress group 70.4% and less than strong progress group 29.6%, *Mdn* = 6) in the Seattle sample, *U* = 69.0 *p* = .709. Therefore, the null hypothesis was retained.

Alt. H4.4: There is a significant relationship between Seattle client's PSS-friends and Seattle client's rating of perceived therapy progress.

Scores on the client's PSS-friends did not significantly differ by client's rating of perceived therapy progress (strong progress group 70.4% and less than strong progress group 29.6%, *Mdn* = 6) in the Seattle sample, *U* = 50.50, *p* = .174. Therefore, the null hypothesis was retained.

Research Question 5: Is There a Relationship Between PSS and Therapeutic Alliance?

A Mann Whitney test was used because although therapeutic alliance was measured on a 6-point scale, all of the participants rated their answers a five or a six and thus this variable was divided into two groups: strong alliance (6) and less than strong alliance (5).

Alt. H5.1: There is a significant relationship between Bogota client's PSS-family and Bogota client's rating of perceived therapeutic alliance.

Scores on the client's PSS-family did not significantly differ based on client's rating of perceived therapeutic alliance (strong alliance group 78.8% and less than strong alliance group 15.2%, *Mdn* = 6) in the Bogota sample, $U = 43.5, p = .245$. Therefore, the null hypothesis was retained.

Alt. H5.2: There is a significant relationship between Bogota client's PSS-friends and Bogota client's rating of perceived therapeutic alliance.

Scores on the client's PSS-friends did not significantly differ based on client's rating of perceived therapeutic alliance (strong alliance group 78.8% and less than strong alliance group 15.2%, *Mdn* = *6*) in the Bogota sample, $U = 59.5, p = .766$. Therefore, the null hypothesis was retained.

Alt. H5.3: There is a significant relationship between Seattle client's PSS-family and Seattle client's rating of perceived therapeutic alliance.

Scores on the client's PSS-fa did not significantly differ based on client's rating of perceived therapeutic alliance (strong alliance group 96.3% and less than strong alliance group 3.7%, *Mdn* = 6) in the Seattle sample, $U = 7.0, p = .439$. Therefore, the null hypothesis was retained.

Alt. H5.4: There is a significant relationship between Seattle client's PSS-friends and Seattle client's rating of perceived therapeutic alliance.

Scores on the client's PSS-friends did not significantly differ based on client's rating of perceived therapy progress (strong alliance group 96.3% and less than strong alliance group 3.7%, *Mdn* = 6) in the Seattle population, $U = 2.0, p = .156$. Therefore, the null hypothesis was retained.

Research Question 6: Does Therapists' Perceived Therapy Progress of Their Clients Differ Between Bogota and Seattle Participants?

Therapist's perceived therapy progress was measured on a 6-point scale but most therapist rated their client's progress as four, five or a six. Thus, this variable was not only extremely skewed, it was in a practical sense categorical and thus divided into two groups: strong progress (6) and less than strong progress (4 or 5). A chi-square test of independence was used to compare this binary representation therapist's perception of therapy progress to city.

Alt. H6.1: There is a significant difference on therapists' perceived therapy progress between Bogota and Seattle.

Scores on therapist's perception of therapy progress did not significantly differ between Bogota (strong progress group 21.2% and less than strong progress group 66.7%, *Mdn* = 4.50) and Seattle (strong progress group 25.9% and less than strong progress group 70.3%, *Mdn* = 5), $\chi^2(1) = 4.92$, $p = .426$. Therefore, the null hypothesis was retained.

Research Question 7: Does Client's Perceived Therapeutic Relationship Differ Between Bogota and Seattle?

As noted, clients' perceived therapeutic relationship was represented as two groups (strong and less than strong), and when numbers in each group were compared for Bogota and Seattle the expected values of some cells were less than five violating assumptions of the chi square test of independence. Thus, Fisher's exact test was used.

Alt. H7.1: There is a significant difference on client's perceived therapeutic alliance between Bogota and Seattle.

There was not a significant difference on client's perceived therapeutic alliance between Bogota (strong alliance group 78.8% and less than strong alliance group 15.2%) and Seattle

(strong alliance group 96.3% and less than strong alliance group 3.7%), Fisher's exact test $p =$ .201. Therefore, the null hypothesis was retained.

Research Question 8: Does Therapist's Perceived Therapeutic Relationship Differ Between Bogota and Seattle?

Therapist's perceived therapeutic alliance was also measured by a 6-point scale, but most therapists rated their alliance five or a six. Thus, this variable was divided into two groups: strong alliance (6) and less than strong alliance (5). A chi-square test of independence was used to compare this binary representation therapist's perception of therapy progress to city.

Alt. H8.1: There is a significant difference on therapist's perceived therapeutic alliance between Bogota and Seattle.

Scores on therapist's perception of therapy alliance did not significantly differ between Bogota (strong alliance group 69.7% and less than strong alliance group 21.2%) and Seattle (strong alliance group 51.9% and less than strong alliance group 33.3%), $\chi^2(1) = 8.07$, $p = .089$. Therefore, the null hypothesis was retained.

Research Question 9: Does the Session-Alliance-Approach (SAA) Rating Scale Differ Between Bogota and Seattle?

To analyze this question a Mann Whitney U test was used.

Alt. H9.1: There is a significant difference on the Session-Alliance-Approach (SAA) rating scale between Bogota and Seattle.

There was not a significant difference on the Session/Alliance/Approach between Bogota ($Mdn = 4.9$) and Seattle ($Mdn = 4.9$), $U = 407.$ 0, $p = .501$. Therefore, the null hypothesis was retained.

CHAPTER V: DISCUSSION

We conducted the present study to test the relationship between social support, therapeutic outcomes, and therapeutic alliance in relation to culture using client data from two counseling centers; one in Seattle, WA and the other one in Bogota, Colombia. We explored cultural perceptions, utilizations, and functions of social support between individualist and collectivist cultures, Seattle and Bogota, respectively. In particular, we evaluated Seattle and Bogota on client's perceived social support and ratings of various aspects of therapy. In addition, we also incorporated therapist's perceptions of therapy progress and alliance, and evaluated similarities and differences between those surveyed in Seattle and Bogota. Lastly, we evaluated the relationship of social support and client's perceptions of therapeutic progress and alliance.

Question 1: Differences in Perceived Social Support Between Individualist and Collectivist Cultures

Perceived social support did not differ significantly based on culture type. Because the hypotheses were based primarily on detecting differences between two cultural groups, Seattle and Bogota, many of the null findings are supportive of similarities, rather than differences, within the sample. The intrinsic differences in the cultural experiences and values of collectivist and individualist cultures contributed to the development of hypotheses focused on divergence, but the data is generally reflective of broad similarities in the sample, regardless of cultural affiliation. Data trends had largely similar responses relative to perceived social support from friends and family, therapeutic alliance, and progress in therapy across cultures. Further, respondents across cultural backgrounds had similar styles of responding to questionnaires about therapy relationships and progress, and social support, with a tendency toward reporting positive

perceptions overall. The similarities across samples also supports the notion of the universality of the importance of social support in therapy and therapeutic outcomes. Among therapists from both cultures, there were no significant differences in the way they described their perceived therapeutic alliance or their clients' progress in therapy. This represents a similarity among therapists across culture about their perception of the therapeutic experience with their clients; interestingly, there is likely a great deal of difference in the way therapy is practiced in these two cultures, despite potential similarities in training. Both cultures have programs in which to train mental health professionals that are composed of structured, supported, and scaffolded course-based programs which serves as the basis for their education and clinical training (Wildy, Peden, & Chan, 2015).

There are, however, several noteworthy differences in the types of perceived support reported by participants in Seattle versus those in Bogota. Data trends show that participants Bogota reported higher familial support than those in Seattle. Relatedly, those in Seattle reported higher levels of support from friends. While these results are not statistically significant, it is important to also acknowledge that these speculations serve as bases for future research, rather than direct inferences based on the results of the present study.

As discussed in the literature review, culture is a primary component in the therapeutic context. As such, values like collectivism and individualism, as a function of culture, color the therapeutic experience. Based on this, the characteristic differences in perceived social support from friends or family may be related to primary cultural differences. Importantly, as Heine (2008) argued, family is the most important aspect of life for those in collectivist cultures. This cultural value may have contributed to the higher ratings of familial support among those from collectivist cultures within this sample.

Another important question about this research inquiry is the very nature of perceived social support across cultures. Given the impact of culture, it is likely that this colors the way social support is sought and experienced. Essentially, someone from a collectivist culture may perceive an action as supportive that someone from an individualist culture would not experience as supportive. This means that even on the same measure of support (i.e., the PSS) people may respond inherently differently based on their cultural background and identity. As a direct example, responses on items from the PSS such as "I rely on my friends/family for emotional support" may look vastly different for people from different cultures; perhaps those from an individualistic society would perceive this question as negative, instead favoring self-reliance, while those in Bogota might interpret this question as aligned with a cultural value of the importance of family closeness. While the PSS is psychometrically sound and approved for translated use, there might still culturally-bound differences in what the measure is aiming to assess; in this case, social support. The inherent and qualitative difference in social support, as well as how it is perceived and experienced, warrants further evaluation, though it is hoped that the slight differences observed within this sample can serve as a model for additional investigations. This is discussed in greater detail as an outlet for future research in a subsequent section.

Question 2: Perceived Therapeutic Progress Between Clients From Bogota and Seattle

Perceived therapeutic progress did not differ significantly based on location. The results of this inquiry demonstrated largely skewed responses, but also a tendency toward dichotomy. While the response options for this variable were measured on a Likert-like scale ranging from one to six, respondents rated their perceived progress as only four, five, or six (where six represents strong agreement and four and five represent less than strong agreement). Because of

this, perceived progress was reconceptualized as categorical; strong agreeance (as indicated by responses of six) and less than strong agreeance (as indicated by responses of four or five). Despite the null findings, this too provides an interesting point of discussion relative to the way participants approached reporting about their progress in therapy.

Importantly, it appears that based on this sample, those in Seattle and Bogota respond similarly to questions about their perceived progress in therapy. Responding similar to questions of perceived therapeutic progress may, in addition, simply represent a psychometric limitation in the wording or presentation of the question, it may also highlight a sample-wide tendency to respond in a positive, prosocial, or self-protective manner; that is, regardless of location, respondents reported only high levels of therapeutic progress. Again, while we avoid direct correlational statements due to the sample size and null findings, we offer the idea that respondents in this sample demonstrated an effort to represent their therapy progress as positive, perhaps to engage in behaviors in order to please and be perceived positively by the investigator or others.

An additional point of consideration is the dichotomization of perceived progress in therapy as strong agreeance and less than strong agreeance. Interestingly, the responses were not dichotomized extremes (i.e., strongly agree and strongly disagree), but instead represented degrees of positivity. This is discussed further as an outlet for future research in terms of predicting or estimating treatment benefits or outcomes relative to treatment progress.

Question 3: Difference in Perceived Social Support Between Friends and Family

While results were nonsignificant, indicating similarity in perceived social support among participants from both Bogota and Seattle, several trends arose from the data. Broadly, respondents rated their progress in therapy in a positive manner, demonstrating a similarity

across cultures. As mentioned previously, respondents in Bogota reported higher familial support than respondents in Seattle. Relatedly, Seattle participants reported higher levels of support from friends than those in Bogota. This may also be reflective of a cultural difference in either the manner of responding, or the importance placed on family relationships and friendships in individualist and collectivist cultures. Further, this necessitates a deeper cultural discussion about what denotes progress in a given culture. In a society such as modern Western culture, with a preoccupation with quick reduction or elimination of suffering, a respondent might consider symptom reduction (i.e., fewer days feeling depressed) to constitute progress, while someone in Bogota may measure their progress in an innately different way.

As noted in the discussion about question one, this too may indicate a difference in how people seek or perceive support based on their culture, identities, and experiences. Again, without overstating the implication, this may be reflective of the importance of family relationships in the collectivist Colombian culture relative to the more individualistic American culture.

This may also indicate differences in access to supports; those in Bogota may be in closer proximity to family members and may, consequently, seek support from family more regularly than friends. In the collectivist culture of Bogota, it may be more appropriate or acceptable to seek support from family members, while in Seattle it may be counter-culture for adults to seek support from family, turning instead to friends. Again, the findings are not statistically significant and the sample is small, so this is a qualitative discussion about the potential pattern we observed in the data, rather than any direct statistical interpretation or generalization.

Question 4: Relationship Between Perceived Social Support and Progress in Therapy

For the inquiries about perceived social support (from family or friends) and perceived

progress in therapy, the findings were not statistically significant. This means that within this sample, no significant relationship was observed between perceived support and perceived progress in therapy. That being said, data trends show higher levels of social support among those who perceived greater therapeutic progress. This is consistent with previous findings which indicate that social support contributes to better therapeutic outcomes (Beckner et al., 2010; LeGrand, 2010; Leibert, 2006; Lourel et al., 2013; Rodríguez & Cohen, 1998; Northey, 2011; Ogrodniczuk et al., 2002; Silverman, 2014; Waddell & Messeri, 2006; Walker, 2012).

Question 5: Relationship Between Perceived Social Support and Therapeutic Alliance

Analyses on the relationship between perceived social support and therapeutic alliance demonstrated nonsignificant findings. Like the question about perceived progress in therapy, items about therapeutic alliance were also dichotomous and were reconceptualized as strong agreeance or less than strong agreeance, as indicated by responses of six and five, respectively. It is noteworthy that on a six-point Likert-like scale, respondents exclusively used five and six (strongly agree and completely agree regarding a statement about their relationship being satisfactory) relative to their relationship with their therapist. Again, this response pattern was consistent across Bogota and Seattle respondents. Those with higher levels of social support also endorsed satisfaction with their therapeutic alliances more frequently, although not at a statistical significant level.

Question 6: Difference in Therapist-Perceived Therapy Progress Between Seattle and Bogota

Among therapists, there was no significant difference in perceived therapy progress of their clients, regardless of location. In line with other findings of this study, while the results were not statistically significant, there are several noteworthy patterns to observe in the data.

Generally, therapists in Bogota had lower levels of perceived progress of their clients in therapy than therapists in Seattle. In this inquiry specifically, it is important to note the sample size; there were only five therapists from Seattle and six from Bogota. Because the sample is so limited, it is difficult to comment on the reason for the trends in the data, however, this may be indicative of a tendency in the Seattle therapists to report in a way that portrays them or their clients in a positive manner, or perhaps within this sample the Seattle therapists simply perceived their clients' progressing more successfully than the therapists in Bogota. This may also point to psychometric limitations of the way this question was presented to respondents (e.g. limited number of options, questions presented at the end of the survey, and not yet validated measures).

Question 7: Difference in Client-Perceived Therapeutic Relationship Between Bogota and Seattle

There were no significant differences among respondents from Bogota and Seattle relative to perceived therapeutic alliance. This points to a general similarity across the sample in the way therapeutic alliance is perceived, regardless of culture. This inquiry, too, was dichotomous in response style, and a large proportion of respondents from both Bogota and Seattle were satisfied with their therapeutic relationships. These results may support the idea that the therapeutic relationship is universally important in the therapy process and treatment outcomes (Hays, 2016; Norcross, 2011).

Question 8: Difference in Therapist-Perceived Therapeutic Relationship Between Bogota and Seattle

While results were not statistically significant, therapists in Bogota had generally stronger ratings of therapeutic alliance with their clients than therapists in Seattle. Interestingly, relative to the previous discussion about therapist-perceived progress in therapy, therapists in Bogota

rated clients' progress as lower, but their therapeutic alliance as stronger. The opposite pattern was observed in the Seattle sample; therapists rated higher levels of progress, but lower levels of therapeutic alliance with clients. Because of the psychometric limitations and nonsignificant results, we do not posit any statements regarding these trends in the data, but do wish to note the interesting role of culture in the way therapists may report about their clients. This, too, may point to an emphasis on outcomes or progress in the Seattle sample, and an emphasis on relational factors in the Bogota sample, again reflective of a potential cultural impact given the nature of collectivism and individualism in perceived therapeutic success.

Question 9: Difference in Session-Alliance-Approach Rating Scale Between Bogota and Seattle

There were no significant differences detected on the Session-Alliance-Approach scale between the Seattle and Bogota samples. Meaning that therapeutic alliance and approach is very similar between these two cultures. Again, several trends arose from the data that necessitate further discussion. In general, respondents from Bogota more frequently had lower ratings of their therapeutic relationship when compared to those in Seattle. In evaluating respondents from the entire sample, people with lower ratings of therapeutic alliance also reported higher levels of social support from family, and people with higher ratings of their therapeutic alliance reported higher levels of social support from friends. This could be indicative of a similarity in the conceptualization of therapeutic alliance as more similar to friendships, and distinct from familial support. However, in the Bogota sample, people that were less satisfied with their therapeutic relationships reported generally higher levels of social support from friends. This may be interpreted, cautiously, as an indication that those in Bogota conceptualize the therapeutic relationship as distinct from friendship, as well. Interestingly, Bogota respondents

had higher ratings in general on the SAA than those in Seattle. This may highlight a psychometric limitation in the way the question was presented or may also be reflective of the impact of culture on the perception of these types of questions and concepts (i.e., perceived therapeutic relationship and progress).

Broad Findings and Themes

This study explored social support relative to therapy progress across two cultures. While the statistical inquiries in this study revealed only nonsignificant results, there are several noteworthy findings that arose from the data.

There are also several noteworthy differences to observe within the data which are generally aligned with the expected impact of culture. Those from Bogota reported higher levels of perceived support from family, while those in Seattle emphasized support from friends. Another difference between Seattle and Bogota respondents was the emphasis on therapeutic relationship versus therapeutic progress; those in Seattle generally had higher ratings of self-perceived therapeutic progress, while those in Bogota had higher self-perceived therapeutic alliance with their therapist.

Regarding the psychometric aspect of the study, participants across cultures, both clients and therapists, had similar patterns of responding on the questionnaires. On several Likert-based scale items, including perceived progress in therapy and perceived therapeutic alliance, respondents only provided positive responses, which essentially dichotomized the item rather than responding on a scale as it was intended. This was true for every respondent, regardless of culture. Because this is counter to the central response bias observed in questionnaire methodologies, this warrants further examination relative to the psychometric properties of the questionnaires used in the present study, which is detailed below as an outlet for future research.

Limitations

Several methodological limitations from this study necessitate discussion, particularly relative to the null findings. Firstly, the sample was small, with a total of 60 participants. This is partially due to the strict exclusionary criteria; because a primary focus of the study was preserving the integrity of cultural affiliation in each sample, extensive requirements were generated in order to reduce interfering factors (i.e., wanting those from the Bogota sample to truly be representative of a collectivist cultural background). It is likely that if a larger sample was obtained, the results may have had more variability and power, increasing the likelihood of observing statistically relevant differences between groups. Relatedly, the small sample contributed to highly skewed data on many measures, dichotomizing items that were meant to be used as scales.

Regarding to the measures, there are several psychometric limitations identified in this study. While the development and use of novel measures is a notable strength of the study, it is also a limitation worth noting given the lack of validated, standardized measures. Because this functioned as a pilot study for these measures, the results revealed several areas where revision is required to improve the sensitivity and validity of the measures on therapy progress and therapeutic alliance. One specific limitation was the inclusion of only one question on perceived progress and perceived therapeutic alliance; it would be beneficial to include multiple items in order to assess, more comprehensively, clients' and therapists' perceptions of their relationship and therapeutic success or progress. This study also relied on self-report measures from both clients and therapists. Currently, there are conflicting stances concerning the validity of self-report data, however, in a study which focused specifically on self-perceived progress, support, and relationships, self-report measures are likely an appropriate choice.

Strengths

This study represented a cross-cultural investigation on social support, therapeutic alliance, and progress in therapy among clients from Bogota and Seattle. Cross-cultural research is limited generally in psychology and is even more limited relative to the specific areas of therapy and social support. To date, there are no studies focused on social support on therapeutic outcomes in collectivist and individualist cultures, although conclusions can be derived from studies that have studied these concepts more separately such as social support and therapeutic outcomes (Beckner et al., 2010; LeGrand, 2010; Leibert, 2006; Lourel et al., 2013; Rodríguez & Cohen, 1998; Northey, 2011; Ogrodniczuk et al.) and social support and culture (Hays, 2016; Heine 2012) but not yet as a grouped phenomena. This investigation represents a novel inquiry in aiming to learn more about the role of culture in social support and the therapeutic process including progress and the therapeutic alliance. Because this research represents a first effort in contributing to literature in this field, the findings, though statistically null, are useful in determining areas for future study. Additionally, the results of this study highlight both similarities and differences across two cultures which have not been previously studied in a comparative manner in this field. This represents a new contribution to cross-cultural literature and can act as a model for further inquiry regarding therapy outcomes, therapy relationships, and social support.

Because of the paucity of literature on cross-cultural differences in social support in therapy, there are few screening tools available to measure social support across culture. This study included the development and piloting of several innovative measures and scales serving as a pilot to support further validity and psychometric testing for the measures. Further, these scales were developed in both English and Spanish, expanding their research potential.

The use of two culturally diverse samples is a primary strength of this study, as well as the inclusion of both therapists and clients from two different cultures. Another strength in the sample is the careful selection of participants to maintain the integrity of measuring two different cultural groups, collectivism and individualism, including the use of rigorous inclusion and exclusion criteria.

Other Factors for Consideration

Another area of consideration is the lack of mental health information gathered. Mental health diagnoses would likely influence the perception of social support as well as perceived therapeutic alliance and progress. It would have also been useful to identify reasons for seeking therapy and determine differences or similarities in different cultures. Relatedly, while we did have an inclusion criterion of having spent a certain amount of time in therapy, we did not collect data on the longevity of the therapeutic relationship or how long the person continued treatment. This also likely influences perceived progress and alliance; for example, someone who engaged in therapy for several years may perceive their therapeutic relationship as stronger, but their progress as less than satisfactory. Further, the data in this study were gathered at only one time. Inclusion of several data collection points would have provided information on changes in perceived progress and alliance across time. This would allow us to evaluate the pace of building therapy relationships across cultures, which is discussed further as a suggestion for future research.

Several other confounding factors should be noted. Clients in the sample were not receiving therapy at the same site, with the same therapist, or for the same length of time. Each of these represents a significant contributing factor to perceived alliance and progress in therapy. Because questionnaires were completed in two different places we are unable to comment on the

way measures were taken by participants; it is also notable that participants were given the option to complete the measure on paper or orally. The samples and measures also varied in culture and language. While the measures created for this study were developed for use in the Spanish language as well as English, neither version is yet validated. Importantly, some measures varied between the English and Spanish versions, particularly the Perceived Support Scale.

Implications

Even though the study did not yield statistically significant results, the findings pave the way for future research to continue exploring cultural differences in social support, therapeutic progress, and therapeutic alliance. The results of this study, and those that follow, can contribute to our understanding of social support factors in clinical practice, assessment, or research. In addition, this research increases awareness of multicultural treatment factors in the field of psychology. On a practical level, the measures developed from this study can be utilized in other future investigations toward integrating multicultural social support factors in interventions with diverse populations. While the results of this study may not be generalizable due to nonsignificant findings and the small sample size, the themes that emerged from the data can be used to inform future clinical and empirical investigations. This is discussed with greater specificity as an opportunity for future research.

Recommendations for Future Research

The findings of this study elucidated several areas of future research. With regard to clinical interventions and evidence-based practices, future research should focus on the importance of social support integration in therapeutic interventions. As evidenced by the themes in these data, there are broad similarities across cultures relative to the perception and

importance of social support in therapeutic outcomes and therapeutic relationships. Clinical training should focus on both the similarities and differences in various cultures relative to social support. That being said, our Bogota sample is small and only representative of the individuals who participated in the study, and their response patterns may not generalize to a larger sample, or a more diverse sample from various collectivist cultures. Future research would benefit from the inclusion of a diverse collectivist sample as well as a diverse individualist sample. And, in general, future research should include larger sample sizes when possible on survey-based methodologies.

For the measures on perceived therapeutic alliance and progress in therapy, future research should adapt these scales to better assess client and therapist perceptions. In order to minimize acquiescence response bias, in which participants tend to agree with statements to please others, it may be beneficial to rephrase statements as questions. Future research should include a positive and negative statement in the measures to evaluate the consistency among the pairs. Adding more items to the Likert scales would, in turn, make the scale more sensitive and would allow participants to have a larger spectrum of answers from which to choose. Relatedly, it might be beneficial for future research to use more precise measures that can identify differences rather than using the current broad scales that tend to have significant negative skew. It may be useful to gather qualitative data regarding the therapeutic relationship specifically, as descriptions of the therapeutic alliance may vary widely across cultures and this could highlight valuable similarities and differences in the therapy experiences of those in different cultures. This may also contribute to the formulation of culturally-informed therapy interventions, as well as additional measures for the assessment of therapy progress and alliance. In addition, adaptive research can implement the use of monitoring perceived support, therapeutic alliance, and

progress in therapy across time would allow for a greater understanding of the pace and trajectory of progress and alliance within therapy across cultures (i.e., determining if therapy relationships develop more slowly in some types of cultures than others, etc.).

The inherent and qualitative difference in social support, as well as how it is perceived and experienced, warrants further evaluation on a broader level. This is not a specific opportunity for research as much as it is an invitation to observe the distinctions, and similarities, between cultures on constructs such as social support. This study, in a small way, highlighted the shared need for support in therapy progress, but also demonstrated distinctions in the importance of familial support or support from friends in different cultures. Social support represents just one facet of the many contributors to therapy relationships and treatment outcomes, and there are many other factors which should be explored in greater detail. In particular, it would be valuable to investigate the role of perceived social support in different types of mental health diagnoses across cultures. For example, a study on the seeking and perceiving of social support among individuals with anxiety across cultures. Because anxiety symptomatology and presentation can vary across cultures (i.e., the inclusion of the term *ataque de nervios* in the DSM 5), it is important to also consider the innate differences in the way mental health conditions manifest in different cultural settings.

Another culturally-bound topic is the idea of perceived progress in therapy. Again, as an invitation for broader consideration, future research should evaluate the factors that influence what is perceived as successful treatment across cultures. As mentioned previously, in Western culture this might be measured by quantifiable symptom reduction as evidenced by objective or subjective measures of distress. This is related also to the current healthcare system in the U.S. which brings about several other intersectional points of discussion relative to the need for

specific types, lengths, and outcomes in treatment in order to be covered by insurance. This is beyond the scope of the present dissertation to discuss, but warrants acknowledgement here as a potential factor in future research.

At an individual level, perceived progress in therapy is another outlet for cross-cultural research. There are many cultural, individual, and mental health factors that might contribute to self-perceived progress in therapy, and future studies should evaluate these factors. One specific suggestion for future research is to evaluate self-compassion relative to perceived therapy progress across cultures. As mentioned previously, given the innate cultural differences we might observe in individualist versus collectivist societies, it is likely that there are implications of culture on the way individuals describe their work in therapy. Further, their reasons for seeking treatment, and the amount of time they invest in treatment may vary. For example, if someone from a collectivist culture sought therapy services to improve functioning in order to support their family, their perceived progress in therapy may be measured by their ability to serve others or engage with family members. This may look vastly different from someone seeking therapy in another culture for different reasons. Having insight that Seattle sought out friend for support and Bogota sought out family for support can be used as a springboard for future research and more focused attention to support and culture particularly between these two cities. Again, these are broad and dynamic cultural considerations which are beyond the scope of this study, but should be at the forefront of future cross-cultural research on therapy.

Conclusion

The current study attempted to address cultural variances in perceptions, utilizations, and functions of social support, particularly between individualist and collectivist cultures, and the potential effect these variances have on the relationship between social support, therapeutic

outcomes, and therapeutic alliance. The lack of research demonstrating the relationships between social support and treatment outcomes and the role culture plays is needed to gain further understanding of these potential important phenomena. Even though the study did not yield statistically significant results, this study was able to highlight areas for future research to continue exploring cultural differences in social support, therapeutic progress, and therapeutic alliance. Focusing on the importance of social support integration in therapeutic interventions and streamlining the measures may be a next step for future research. It is hoped that this study may lead to further examination of social support with regards to therapeutic treatment and culture in order to improve mental health outcomes.

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Appendix A:

Participation Forms and Recruitment Materials

Item A. Informed consent, English Version

Cultural Differences, Social Support, and Therapy Outcomes Adult Consent Form

Researchers at Antioch University Seattle are asking you to take part in a research study exploring the relationship between cultural differences, social support, and therapy outcomes.

The study will help us learn about the collectivist and individualist cultural differences in Perceived Social Support (PSS) as it relates to therapeutic outcomes. More specifically, it seeks to understand how Seattle and Bogota compare or differ when it comes to this phenomenon, and how these two different geographical locations can inform individualistic and collectivist cultures at large thus widening the understanding of social support as it relates to different cultures. We will use the results of the study to improve how clinicians understand and utilize social support factors in interventions. In addition, it seeks to increase awareness of multicultural treatment factors in the field of psychology. If you agree to take part in this study, you will not be identified individually in the research. Some of your demographic information will be used, such as your age and gender, but it will not be linked to your name. Participation in this study is not considered part of your therapy and participation or a decision to not participate will have no impact on your therapy or your standing at the clinic.

You will be asked to fill out three questionnaires sometime between the 8th and 10th session of therapy as well as a demographic questionnaire. At that time your part in the study will be over.

The benefit to you in taking part of this study is that you will have someone reliable with whom to talk. The study may help to provide insights into the relationship between culture and social support as it relates to therapeutic outcomes in addition to receiving a $5.00 gift card for the nearest coffee shop.

You may experience some discomfort due to the nature of the questions/statements being asked in the questionnaires. You are free to refuse to answer any question for any reason. The researchers and the staff at LightHeart Psychological Associates will attempt to prevent or minimize any risks to you. No one outside of the researchers and staff will know about your participation in this research study.

The researchers have tried to make sure no one else can know how you answer the questionnaire and interview. Your name will not be used on the study form with your answers. Only a special code number will be used and be kept in a locked filing cabinet in a locked office.

Taking part is voluntary. You may refuse to answer any question, but we hope you answer as many questions as you can.

If you have any questions about the study, you may contact Veronica Felstad the primary investigator at (XXX) XXX-XXXX or via email at vfelstad@antioch.edu; Chris Heffner Dissertation Chair at cheffner@antioch.edu; Dana Waters Committee Member at dwaters@antioch.edu, or Juan Camilo Restrepo Committee Member at juanreca@unisabana.edu.co.

If you have any questions about your rights as a research participant, you may contact Dr. Mark Russell, Chair of the Antioch University Seattle IRB, at 206-268-4837.

Thank you for helping build a better community for all people.

I agree to take part in the Antioch University Seattle psychology study about the relationship of culture and social support as it relates to therapeutic outcomes. My questions have been answered. I may refuse to answer any question I want or withdraw from the study at any time.

_____
Printed Name of Participant

_____
Signature of Participant   Date

_____
Printed Name of Investigator

_____
Signature of Investigator   Date

Item B. Informed consent, Spanish Version

Diferencias Culturales, Apoyo Social, y Progreso Terapéutico Formulario de Consentimiento pare Adultos

Los investigadores de la Universidad de Antioch en Seattle le piden que participe en un estudio de investigación que explora la relación entre las diferencias culturales, el apoyo social y el progreso en la terapia psicológica individual.

El estudio nos ayudará a conocer las diferencias culturales colectivistas e individualistas en el Apoyo social percibido (PSS) en relación con los resultados terapéuticos. Más específicamente, busca comprender cómo Seattle y Bogotá se comparan o difieren cuando se trata de este fenómeno, y cómo estas dos ubicaciones geográficas tan diferentes pueden informar a las culturas individualistas y colectivistas a un nivel macro, ampliando así la comprensión del apoyo social en relación con las diferentes culturas. Utilizaremos los resultados del estudio para mejorar la forma en que los médicos comprenden y utilizan los factores de apoyo social en las intervenciones. Además, busca aumentar la conciencia de los factores de tratamiento multicultural en el campo de la psicología. Si acepta participar en este estudio, no será identificado individualmente en la investigación. Se utilizará parte de su información demográfica, como su edad y género, pero no estará vinculada a su nombre. La participación en este estudio no se considera parte de su terapia y la participación o la decisión de no participar no tendrán ningún impacto en su terapia o su permanencia en la clínica.

Se le pedirá que complete tres cuestionarios entre la 8ª y 10ª sesión de terapia, así como un cuestionario demográfico. En ese momento su parte en el estudio habrá terminado.

Al participar en este estudio, usted tendrá a alguien confiable con quien hablar así como recursos para encontrar apoyo social en la comunidad. Además, recibirá un cupón/bono de $ 6,000 para la cafetería/tienda más cercana.

Es posible que experimente cierta incomodidad debido a la naturaleza de las preguntas/declaraciones que se formulan en los cuestionarios y es libre de negarse a contestar cualquier pregunta. Los investigadores y el personal del Centro de Servicios de Psicología (CSP) intentarán prevenir o minimizar cualquier riesgo para usted. Nadie fuera de los investigadores y el personal sabrá de su participación en este estudio de investigación.

Los investigadores han tratado de asegurarse de que nadie más pueda saber cómo responde el cuestionario y la entrevista. Su nombre no se utilizará en el formulario de estudio con sus respuestas. Solo se usará un número de código especial y se guardará en un archivador cerrado en una oficina cerrada.

Participar es voluntario. Puede negarse a responder cualquier pregunta, pero esperamos que responda todas las preguntas que pueda.

Si tiene alguna pregunta sobre el estudio, puede contactar a Veronica Felstad, la investigadora principal al (XXX) XXX-XXXX o por correo electrónico a vfelstad@antioch.edu, director de tesis Chris Heffner al cheffner@antioch.edu, miembro de comité Dana Waters al dwaters@antioch.edu, o miembro de comité en Bogotá Juan Camilo Restrepo al juanreca@unisabana.edu.co. Si tiene alguna pregunta sobre sus derechos como participante en la investigación, puede comunicarse con el Dr. Mark Russell, Presidente del comité de Ética de la Universidad de Antioch en Seattle al 206-268-4837 o al mrussell@antioch.edu.

Gracias por ayudar a construir una comunidad mejor para todas las personas.

Estoy de acuerdo en participar en el estudio de psicología de la Universidad de Antioch en Seattle con la ayuda del CSP sobre la cultura y el apoyo social en relación con los resultados terapéuticos. Mis inquietudes has sido resueltas. Puedo negarme a contestar cualquier pregunta que desee o retirarme del estudio en cualquier momento.

_____
Nombre del participante

_____
Firma del participante   Fecha

_____
Nombre del Investigador Principal   Fecha

_____
Firma del Investigador Principal   Fecha

Item C. Confidentiality agreement, English Version

Cultural Differences, Social Support, and Therapy Outcomes: A Comparative Study Between Bogotá and Seattle Confidentiality Agreement

I, _____, agree to assist the primary investigators with this study by recruiting based on inclusion and exclusion criteria provided. I agree to maintain full confidentiality when performing these tasks.

Specifically, I agree to:

1. Keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., USBs, tapes, transcripts) with anyone other than the primary investigators;

2. Hold in strictest confidence the identification of any individual that may be revealed during the course of performing the research tasks;

3. Not make copies of any raw data in any form or format (e.g., USBs, tapes, transcripts), unless specifically requested to do so by the primary investigator;

4. Keep all raw data that contains identifying information in any form or format (e.g., USBs, tapes, transcripts) secure while it is in my possession. This includes:
   - Keeping all digitized raw data in computer password-protected files and other raw data in a locked file;
   - Closing any computer programs and documents of the raw data when temporarily away from the computer;
   - Permanently deleting any e-mail communication containing the data; and

5. Give, all raw data in any form or format (e.g., USBs, tapes, transcripts) to the primary investigator when I have completed the research tasks;

6. Destroy all research information in any form or format that is not returnable to the primary investigators (e.g., information stored on my computer hard drive) upon completion of the research tasks.

Provide the following contact information for research assistant:

Printed name of Director: _____

Address: _____

Telephone number: _____

Signature of Director: _____Date _____

Printed name of primary investigator_____

Signature of primary investigator _____Date_____

Item D. Confidentiality agreement, Spanish Version

Diferencias Culturales, Apoyo Social, y Progreso Terapéutico Formulario de Acuerdo de Confidencialidad

Yo, _____, acepto ayudar a los la investigadora con este estudio reclutando según los criterios de inclusión y exclusión proporcionados. Estoy de acuerdo en mantener total confidencialidad al realizar estas tareas.

Específicamente, acepto:

1. Mantener la confidencialidad de toda la información de la investigación que se comparte conmigo y no discutir ni compartir la información en ninguna forma o formato (digital, oral, o en escrito) con nadie más que con los investigadores principales;

2. Mantener en estricta confidencialidad la identificación de cualquier individuo que pueda revelarse durante el curso de la realización de las tareas de investigación;

3. No hacer copias de ningún dato en ninguna forma o formato (digital o en escrito), a menos que el investigador lo solicite específicamente;

4. Mantener todos los datos sin procesar que contengan información de identificación en cualquier forma o formato (digital, oral, o en escrito) seguros mientras estén en mi poder. Esto incluye:
    *   Mantener todos los datos sin procesar digitalizados en archivos protegidos por contraseña de computadora y otros datos sin procesar en un archivo bloqueado;
    *   Cerrar cualquier programa informático y documentos de los datos originales cuando me encuentre temporalmente alejado de la computadora;
    *   Eliminar de forma permanente cualquier comunicación de correo electrónico que contenga los datos;

5. Entregar todos los datos sin procesar en cualquier forma o formato (digital, oral, o en escrito) al investigador principal cuando haya completado las tareas de investigación;

6. Destruya toda la información de la investigación en cualquier forma o formato que no sea retornable a los investigadores principales (por ejemplo, la información almacenada en el disco duro de mi computadora) al completar las tareas de investigación.

Proporcione la siguiente información de contacto para el asistente de investigación:

Nombre del director: _____
Dirección: _____
Número de teléfono: _____
Firma del Director: _____Fecha _____
Nombre del investigador: _____
Firma del investigador: _____Fecha_____

Item E. Permission letter for recruitment, English Version

Permission Letter to Recruitment Sites

I am Veronica Felstad a doctoral PsyD student in the Clinical Psychology program at Antioch University, Seattle. I am conducting a study on the cultural differences on social support as it relates to therapeutic process.

Prior research suggested that social support is a protective factor for general well-being and mental health. I am asking for your participation in order to identify potential participants, as well as to provide the space to conduct the study. I am looking to recruit individuals who meet the following criteria:

- Be at least 18 years of age
- Be English speaking
- Be concurrently enrolled in therapy
- Not have schizophrenia, not be actively psychotic, not be in crisis, or not have any sort of developmental disabilities.

I understand that records are confidential, and all effort will be made to maintain confidentiality of participants that may be recruited from your site. We will omit identifying information, such as the name of the participant or name of the site when reporting our data after the conclusion of the study. Additionally, each therapist and client will receive incentives for participating in the study but no compensation will be given to sites that aid in recruiting. Participation is voluntary.

I am asking to put up fliers in your lobby to recruit participants for this study. We ask that participants are self-selected if they feel that they may fit the limits of the research, as well as I would like for therapists to introduce the study.

If you have any questions about the study, you may contact Veronica Felstad the primary investigator at (425) 442-2262 or via email at vfelstad@antioch.edu; Chris Heffner Dissertation Chair at cheffner@antioch.edu; Dana Waters Committee Member at dwaters@antioch.edu, or Juan Camilo Restrepo Committee Member at juanreca@unisabana.edu.co.

Thank you for your help.

Sincerely,

Veronica Felstad, M.A., LMCHA, PsyD student

Item F. Permission letter for recruitment, Spanish Version

Carta de Permiso a Sitios de Reclutamiento

Soy Veronica Felstad estudiante de doctorado en el programa PsyD de Psicología Clínica en la Universidad de Antioch, Seattle. Estoy realizando un estudio sobre las diferencias culturales en el apoyo social en relación con el proceso terapéutico.

Investigaciones anteriores sugirieron que el apoyo social es un factor protector para el bienestar general y la salud mental. Solicito su participación para identificar posibles participantes, así como para proporcionar el espacio para llevar a cabo el estudio. Estoy buscando reclutar personas que cumplan los siguientes criterios:
   • Tiene al menos 18 años de edad.
   • Habla Español
   • Esta inscrito/a simultáneamente en terapia
   • No tiene esquizofrenia, no es activamente psicótico/a, no esta en crisis, o ningún tipo de discapacidades del desarrollo.

Entiendo que los registros son confidenciales y se hará todo lo posible para mantener la confidencialidad de los participantes que pueden ser reclutados desde su clínica. Omitiré la información de identificación, como el nombre del participante o el nombre de la clínica al informar nuestros datos después de la conclusión del estudio. Además, cada terapeuta y cliente recibirán incentivos por participar en el estudio, pero no se otorgará ninguna compensación a los sitios que ayuden en el reclutamiento. Participación es voluntaria.

Solicito colocar volantes en su lobby para reclutar participantes para este estudio. Pedimos que los participantes sean auto-seleccionados si sienten que pueden ajustarse a los límites de la investigación, pero adicionalmente nos gustaría que lo terapeutas introdujeran el estudio.

Si tiene alguna pregunta sobre el estudio, puede contactar a Veronica Felstad, la investigadora principal al (XXX) XXX-XXXX o por correo electrónico a vfelstad@antioch.edu; Director de tesis Chris Heffner al cheffner@antioch.edu; Miembro de comité Dana Waters al dwaters@antioch.edu, o miembro de comité en Bogotá Juan Camilo Restrepo al juanreca@unisabana.edu.co.

Gracias por su ayuda.

Sinceramente,

Veronica Felstad, M.A., LMCHA, PsyD estudiante

Item G. Recruitment flyer, English Version

Recruitment Flyer

I am Veronica Felstad a doctoral PsyD student in the Clinical Psychology program at Antioch University, Seattle. I am conducting a study on the cultural differences on social support as it relates to therapeutic process.

Prior research suggested that social support is a protective factor for general well-being and mental health.

In order to participate, you must be:

- Be at least 18 years of age
- Be English speaking
- Be concurrently enrolled in therapy
- Have one or more of these symptoms:

Sadness ☐   Tearful ☐

Hopelessness ☐   Overwhelmed ☐

Restlessness ☐   Impulsive ☐

Irritability ☐

Loss of interest ☐

Trouble concentrating ☐

Trouble making simple decisions ☐

Fear ☐

Worry ☐

Avoiding situations because of difficult emotions ☐

Thoughts of death or suicide ☐

Difficulty concentrating ☐

Trouble sleeping ☐

Muscle pains ☐

Thoughts, feelings, or behaviors that interfere with daily activities ☐

Performing repetitive behaviors ☐

Sweating more than normal ☐

Feeling shaky ☐

Increased heart rate ☐

Scared of dying ☐

Scared ☐

Nightmares ☐

Feeling on guard ☐

Easily startled ☐

Difficulty across settings ☐

Your participation in this research is completely voluntary and anonymous, and it is your right to choose to end your participation at any time with no repercussions. By participating in the study, you will receive a $5 Starbucks gift card.

To participate in this study, I am asking you to fill out three questionnaires in addition to a demographic questionnaire that should take about 20 minutes. Your name will not be recorded, and all effort will be made to protect your confidentiality. If you wish to participate, please let your therapist know and they will provide the questionnaires.

If you have any questions about the study, you may contact Veronica Felstad the primary investigator at (XXX) XXX-XXXX or via email at vfelstad@antioch.edu; Chris Heffner Dissertation Chair at cheffner@antioch.edu; Dana Waters Committee Member at dwaters@antioch.edu, or Juan Camilo Restrepo Committee Member at juanreca@unisabana.edu.co.

Thank you for your help.

Sincerely,

Veronica Felstad, M.A., LMCHA, PsyD student

Item H. Recruitment flyer, Spanish Version

Folleto de Reclutamiento

Soy Veronica Felstad estudiante de doctorado en el programa PsyD de Psicología Clínica en la Universidad de Antioch, Seattle. Estoy realizando un estudio sobre las diferencias culturales en el apoyo social en relación con el proceso terapéutico.

Investigaciones anteriores sugirieron que el apoyo social es un factor protector para el bienestar general y la salud mental.

Para participar debes:
- Tener al menos 18 años de edad.
- Hablar Español
- Estar inscrito/a simultáneamente en terapia
- Tener uno o más de estos síntomas:

Tristeza ☐

Desesperanza ☐

Inquietud ☐

Irritabilidad ☐

Pérdida de interés ☐

Problemas para concentrarse ☐

Problemas para tomar decisiones simples ☐

Miedo ☐

Preocupación ☐

Evitar situaciones por emociones difíciles ☐

Pensamientos de muerte o suicidio ☐

Dificultad para concentrarse ☐

Problemas para dormir ☐

Dolores musculares ☐

Impulsivo ☐

Pensamientos, sentimientos o comportamientos que interfieren con sus actividades diarias ☐

Realizar conductas repetitivas

Sudar más de lo normal ☐

Sentirse tembloroso ☐

Aumento de la frecuencia cardíaca ☐

Miedo de morir ☐

Asustado ☐

Pesadillas ☐

Sentirse en guardia ☐

Ser fácilmente asustado ☐

Dificultad en varias áreas de vida ☐

Lloroso ☐

Abrumado ☐

Su participación en esta investigación es completamente voluntaria y anónima, y es su derecho elegir finalizar su participación en cualquier momento sin repercusiones. Al participar en el estudio, recibirá un cupón de $6,000 para la tienda mas cercana.

Para participar en este estudio, le pido que complete tres cuestionarios y un formulario de datos sociodemográficos que deben tomar alrededor de 20 minutos. Su nombre no será registrado, y se hará todo lo posible para proteger su confidencialidad.

Si desea participar, infórmeselo a su terapeuta y ellos le proporcionarán los cuestionarios. Si tiene alguna pregunta sobre el estudio, puede contactar a Veronica Felstad, la investigadora principal al (XXX) XXX-XXXX o por correo electrónico a vfelstad@antioch.edu; Director de tesis Chris Heffner al cheffner@antioch.edu; Miembro de comité Dana Waters al dwaters@antioch.edu, o miembro de comité en Bogotá Juan Camilo Restrepo al juanreca@unisabana.edu.co.

Gracias por su ayuda.

Sinceramente,
Veronica Felstad, M.A., LMCHA, PsyD estudiante

Appendix B:

Measures

Item A. Demographic questionnaire for therapists, English Version

Name of therapist: _____

Highest level of studies _____

Diagnosis of client: _____

Symptoms endorsed:

Sadness ☐

Hopelessness ☐

Restlessness ☐

Irritability ☐

Loss of interest ☐

Trouble concentrating ☐

Trouble making simple decisions ☐

Fear ☐

Worry ☐

Avoiding situations because of difficult
emotions ☐

Thoughts of death or suicide ☐

Difficulty concentrating ☐

Trouble sleeping ☐

Muscle pains ☐

Thoughts, feelings, or behaviors that
interfere with daily activities ☐

Performing repetitive behaviors ☐

Sweating more than normal ☐

Feeling shaky ☐

Increased heart rate ☐

Scared of dying ☐

Scared ☐

Nightmares ☐

Feeling on guard ☐

Easily startled ☐

Difficulty across settings ☐

Tearful ☐

Overwhelmed ☐

Impulsive ☐

Intervention used: _____

Theoretical Orientation: _____

How many sessions did you complete with this client? _____

On a scale from 1-6, 1 being no improvement and 6 being great improvement please rate your improvement and your relationship with your client.

I client has made satisfactory progress in this therapy.

1. Completely disagree
2. Mostly disagree
3. Slightly disagree
4. Slight agree
5. Mostly agree
6. Completely agree

The therapist-client relationship is satisfactory

1. Completely disagree
2. Mostly disagree
3. Slightly disagree
4. Slight agree
5. Mostly agree
6. Completely agree

Item B. Demographic questionnaire for therapists, Spanish Version

Datos Sociodemográficos del Terapeuta

Nombre del terapeuta: _____

Nivel de Estudio: _____

Diagnostico de su cliente: _____

Síntomas indicados:

Tristeza ☐

Desesperación ☐

Inquietud ☐

Irritabilidad ☐

Pérdida de interés ☐

Problemas para concentrarse ☐

Problemas para tomar decisiones simples ☐

Temo ☐

Preocupación ☐

Evita situaciones por emociones difíciles ☐

Pensamientos de muerte o suicidio ☐

Dificultad para concentrarse ☐

Problemas para dormir ☐

Dolores musculares ☐

Pensamientos, sentimientos o conductas que interfieren con las actividades diarias ☐

Realiza comportamientos repetitivos ☐

Suda más de lo normal ☐

Sentirse tembloroso ☐

Aumento de la frecuencia cardíaca ☐

Miedo de morir ☐

Asustado ☐

Pesadillas ☐

Sentirse en guardia ☐

Fácilmente asustado ☐

Dificultad en varias áreas de su vida ☐

Lloroso ☐

Abrumado ☐

Impulsivo ☐

Intervención utilizada: _____

Orientación teórica: _____

Cuantas sesiones se realizaron con el cliente: _____

En una escala del 1 al 6, 1 siendo no ha mejorado y 6 siendo ha mejorado mucho, evalúe su mejora y su relación con su client

El cliente hizo progreso satisfactorio en

esta terapia.

1. Completamente en desacuerdo
2. Mayormente en desacuerdo
3. Ligeramente en desacuerdo
4. Ligeramente de acuerdo
5. Mayormente de acuerdo
6. Completamente de acuerdo

La relación terapeuta-cliente es satisfactoria.

1. Completamente en desacuerdo
2. Mayormente en desacuerdo
3. Ligeramente en desacuerdo
4. Ligeramente de acuerdo
5. Mayormente de acuerdo
6. Completamente de acuerdo

Item C. Demographic questionnaire for clients, English Version

Age: _____

Sex: _____

Race: _____

Ethnicity: _____

Highest Level of Education:

No schooling completed ☐

Elementary school ☐

Middle school ☐

Some high school, no diploma ☐

High school graduate, diploma or the equivalent (for example: GED) ☐

Some college credit, no degree ☐

Trade/technical/vocational training ☐

Associate degree ☐

Bachelor's degree ☐

Master's degree ☐

Professional degree ☐

Doctorate degree ☐

Relationship Status (Select one):

Single ☐

Partnered ☐

Married ☐

Divorced ☐

Widowed ☐

Occupation (Select as many as it applies)

Employed ☐

Student ☐

Independent/Self--employed ☐

Retired ☐

Stay at home ☐

Unemployed ☐

Other _____

Employment Status (Select one):

Full-time ☐

Part-time ☐

Unemployed/Student ☐

Who do you live with? (Select as many as it applies):

Alone ☐

Parents ☐

Siblings ☐

Grandparents ☐

Spouse/partner ☐

Children ☐

With roommates ☐

Other: _____

On a scale from 1-6, 1 being no improvement and 6 being great improvement please rate your improvement and your relationship with your therapist.

I have made satisfactory progress in this therapy.

1. Completely disagree
2. Mostly disagree
3. Slightly disagree
4. Slight agree
5. Mostly agree
6. Completely agree

The therapist-client relationship is satisfactory

1. Completely disagree
2. Mostly disagree
3. Slightly disagree
4. Slight agree
5. Mostly agree
6. Completely agree

Item D. Demographic questionnaire for clients, Spanish Version

Datos Sociodemográficos del Cliente

Edad: _____

Sexo: _____

Raza: _____

Nacionalidad: _____

Nivel Estudios:

Primaria ☐

Bachiller ☐

Técnico ☐

Profesional ☐

Postgrado ☐

Doctorado ☐

Estado Civil (seleccione uno)

Soltero ☐

Unión libre ☐

Casado ☐

Divorciado ☐

Viudo ☐

Ocupación (seleccione uno)

Empleado ☐

Estudiante ☐

Independiente ☐

Pensionado ☐

Hogar ☐

Otro _____

Estado de empleo o Jornada Laboral (seleccione uno):

Tiempo completo (aprox. 40 horas a la semana) ☐

Medio Tiempo (aprox. 20 horas a la semana) ☐

Desempleado/Estudiante ☐

Con quien vive? (seleccionar varias si aplica)

Solo ☐

Padres ☐

Hermanos ☐

Abuelos ☐

Esposo/a ☐

Hijos ☐

Comparte su vivienda con personas diferentes a su familia ☐

Otro _____

En una escala del 1 al 6, 1 siendo no ha mejorado y 6 siendo ha mejorado mucho, evalúe su mejora y su relación con su terapeuta.

Hice progresos satisfactorios en esta terapia.

1. Completamente en desacuerdo
2. Mayormente en desacuerdo
3. Ligeramente en desacuerdo
4. Ligeramente de acuerdo
5. Mayormente de acuerdo
6. Completamente de acuerdo

La relación terapeuta-cliente es satisfactoria

1. Completamente en desacuerdo
2. Mayormente en desacuerdo
3. Ligeramente en desacuerdo
4. Ligeramente de acuerdo
5. Mayormente de acuerdo
6. Completamente de acuerdo

Item E. Session-Alliance-Approach (SAA) Rating Scale, English Version

1. I felt understood, heard, and respected in therapy.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

2. We talked about what I want to talk about in therapy.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

3. We worked on what I wanted to work on in therapy.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

4. My therapist's approach is a good fit for me.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

5. This therapy and the skills that I have acquired helped me deal more effectively with my problems.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

6. My relationship with my therapist is good.

Strongly disagree   Strongly agree

1   2   3   4   5

_____

7. The language used by my therapist was appropriate/understandable.

Strongly disagree   Strongly agree

1   2   3   4   5

---

8. The therapist was friendly.

Strongly disagree   Strongly agree

1   2   3   4   5

---

9. My therapist and I work well together.

Strongly disagree   Strongly agree

1   2   3   4   5

---

10. I felt there was something missing in this therapy.

Strongly disagree   Strongly agree

1   2   3   4   5

Item F. Session-Alliance-Approach (SAA) Rating Scale, English Version

Sesión-Alianza-Enfoque Escala

1. Me sentí comprendido, escuchado, y respetado en la terapia.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

2. Hablamos de lo que quería hablar en terapia.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

3. Trabajamos en lo que quería trabajar en terapia.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

4. El método usado por el terapeuta para llevar a cabo la sesión, fue bueno para mí.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

5. Esta terapia y las habilidades que he adquirido me ayudaron a lidiar más eficazmente con mis problemas.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

6. El terapeuta me inspiro confianza.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

_____

7. El lenguaje utilizado por mi terapeuta fue apropiado / comprensible.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

---

8. El terapeuta fue amable.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

---

9. Mi terapeuta y yo trabajamos bien juntos.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

---

10. Sentí que faltaba algo en esta terapia.

Totalmente en desacuerdo   Totalmente de acuerdo

1   2   3   4   5

Item G. Perceived Social Support Family, (PSS-fa), English Version

PSS-Fa

Directions: The statements that follow refer to feelings and experiences, which occur to most people at one time or another in their relationships with their families. For each statement there are three possible answers: Yes, No, Don't know. Please mark with an X the answer you choose for each item.

Number	Statement	Yes	No	Don't know
1	My family gives me the moral support I need.			
2	I get good ideas about how to do things or make things from my family.			
3	Most other people are closer to their family than I am.			
4	When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.			
5	My family enjoys hearing about what I think.			
6	Members of my family share many of my interests.			
7	Certain members of my family come to me when they have problems or need advice.			
8	I rely on my family for emotional support.			
9	There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.			
10	My family and I are very open about what we think about things.			
11	My family is sensitive to my personal needs.			
12	Members of my family come to me for emotional support.			
13	Members of my family are good at helping me solve problems.			
14	I have a deep sharing relationship with a number of members of my family.			

15	Members of my family get good ideas about how to do things or make things from me.			
16	When I confide in members of my family, it makes me uncomfortable.			
17	Members of my family seek me out for companionship.			
18	I think that my family feels that I'm good at helping them solve problems.			
19	I don't have a relationship with a member of my family that is as close as other people's relationships with family members.			
20	I wish my family were much different.			

Item H. Perceived Social Support Family, (PSS-fa), Spanish Version

PSS-Fa (16 ítems)

Instrucciones: Las siguientes frases se refieren a los sentimientos y experiencias, que cada persona siente en las relaciones con sus familias. Para cada afirmación hay tres respuestas posibles: sí, no, no sé. Por favor marque con una X la respuesta que elija para cada ítem.

Numero	Ítem	Si	No	No sé
1	Mi familia me da mucho ánimo.			
2	Yo recibo consejos prácticos de mi familia.			
3	La mayoría de la gente es más cercana a su familia, que yo a la mía.*			
4	Cuando comparto mis opiniones y sentimientos personales con mis familiares más cercanos, me da la impresión que los hace sentir incómodos.*			
5	A mi familia le gusta escuchar lo que pienso.			
6	Los miembros de mi familia comparten muchos de mis gustos e intereses.			
7	Algunos de mis familiares se acercan a mí cuando tienen problemas o necesitan ser aconsejados.			
8	Dependo de mi familia para apoyo emocional.			
9	Cuando me siento triste o decepcionado(a), puedo contárselo a alguien de mi familia sin arrepentirme de ello después.			
10	Mi familia y yo expresamos abiertamente nuestras opiniones.			
11	Mi familia está consciente de mis necesidades personales.			
12	Mis familiares hablan conmigo cuando se sienten mal.			
13	Mi familia es de gran utilidad para ayudarme a resolver mis problemas.			
14	Tengo un vínculo muy cercano con varios de mis familiares.			
15	Le doy a mis familiares consejos útiles y prácticos.			
16	Mis familiares dicen que soy útil ayudándoles a resolver sus problemas.			

Item I. PSS-fr, English Version

PSS-Fr

Directions: The statements that follow refer to feelings and experiences, which occur to most people at one time or another in their relationships with friends. For each statement there are three possible answers: Yes, No, Don't know. Please mark with an X the answer you choose for each item.

Number	Statement	Yes	No	Don't know
1	My friends give me the moral support I need.			
2	Most other people are closer to their friends than I am.			
3	My friends enjoy hearing about what I think.			
4	Certain friends come to me when they have problems or need advice.			
5	I rely on my friends for emotional support.			
6	If I felt that one or more of my friends were upset with me. I'd just keep it to myself.			
7	I feel that I am on the fringe in my circle of friends.			
8	There is a friend I could go to if I were just feeling down, without feeling funny about it later.			
9	My friends and I are very open about what we think about things.			
10	My friends are sensitive to my personal needs.			
11	My friends come to me for emotional support.			
12	My friends are good at helping me solve problems.			
13	I have a deep sharing relationship with a number of friends.			
14	My friends get good ideas about how to do things or make things from me.			
15	When I confide in friends, it makes me feel uncomfortable.			
16	My friends seek me out for companionship.			

17	I think that my friends feel that I'm good at helping them solve problems.			
18	I don't have a relationship with a friend that is as intimate as other people's relationships with friends.			
19	I've recently gotten a good idea about how to do something from a friend.			
20	I wish my friends were much different.			

Item J. PSS-fr, Spanish Version

PSS-Fr (12 ítems)

Instrucciones: Las siguientes frases se refieren a los sentimientos y experiencias, que cada persona siente en las relaciones con sus amigos. Para cada afirmación hay tres respuestas posibles: sí, no, no sé. Por favor marque con una X la respuesta que elija para cada ítem.

Numero	Ítem	Si	No	No sé
1	Mis amigos me dan muchos ánimos.			
2	La mayoría de la gente es más cercana a sus amigos, que yo a los míos.*			
3	A mis amigos les gusta escuchar lo que pienso.			
4	Dependo de mis amigos para apoyo emocional.			
5	Siento que encajo un poco mal en mi círculo de amigos.*			
6	Cuando me siento triste o decepcionado(a), puedo contárselo a alguno de mis amigos sin arrepentirme de ello después.			
7	Mis amigos están conscientes de mis necesidades personales.			
8	Mis amigos son de gran utilidad para ayudarme a resolver mis problemas.			
9	Le doy a mis amigos consejos útiles y prácticos.			
10	Mis amigos dicen que soy útil ayudándoles a resolver sus problemas.			
11	Los amigos de otros muestran más cariño y preocupación entre ellos, que los míos por mí.*			
12	Desearía que mis amigos fueran muy diferentes.*			

Appendix C:

Resource List and Contact Information

Item A. Resource list – English Version

List of resources for Emotional and Social Support

Psychology Today - Support groups in Washington
https://groups.psychologytoday.com/rms/state/Washington.html

Mental Health America – Find Support Groups
http://www.mentalhealthamerica.net/find-support-groups

National Alliance on Mental Illness Seattle
http://www.nami-greaterseattle.org/

Office of Disease Prevention and Health Promotion – Health finder
https://healthfinder.gov/FindServices/

Anxiety and Depression Association of America – Support Groups
https://www.adaa.org/supportgroups

Research
National Institute of Health – *Social Support and Resilience to Stress*
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921311/

National Institute of Health – *Social and Emotional Support and its Implications for Health*
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2729718/

Support Services
King County 24-Hour Crisis Line – 866-4-CRISIS, 206-461-3222
https://crisisclinic.org/find-help/crisis-line/

Suicide hotlines – 800-273-TALK, 800-273-8255, 800-SUICIDE, 800-784-2433
https://suicidepreventionlifeline.org/

Emergency services – 911

Item B. Resource list – Spanish Version

Lista de Recursos Sobre el Apoyo Emocional y Social

Psicologos Especializados en Psicoterapia en Chia
https://www.psicologos.com.co/centros/psicoterapia/chia

Star of Service
https://www.starofservice.co/dir/cundinamarca/sabana-centro/chia/psicologia#_

Paginas Amarillas
https://www.paginasamarillas.com.co/bogota
http://www.laspaginasamarillasdecolombia.com/sabana/chia.php?id_ciudad=84

Psicomundo
http://www.psicomundo.com/directorio/index/refinar/ciudadId/54/query/

Secretaria Distrital de Seguridad, Convivencia y Justicia
https://scj.gov.co/es/lineas-emergencia

Policía Nacional Teléfono: 112
Líneas de Emergencia Teléfono: 123
Cruz Roja Teléfono: 132
Gaula Policía Teléfono: 165

Clínica Fundación Santa Fe de Bogota
https://www.fsfb.org.co/wps/portal/fsfb/inicio/servicioensalud
Teléfono: +57 1 6030303

Clínica De Marly
http://marly.com.co
Teléfono: +57 1 3436600

Clínica del Country
https://www.clinicadelcountry.com
Teléfono: +57 1 5300470

Hospital la Hortua Hospital San Juan de Dios
Troncal Carrera 10 #1 - 59 Sur, Bogotá, Colombia
Teléfono: +57 311 5768934

Clínica de nuestra señora de la paz
http://www.cllapaz.com.co
Teléfono: (57 1) 2921277

Clínica Monserrat

http://www.clinicamontserrat.com.co/web/
051-259-6000

Hospital San Antonio de Chía
http://www.esehospitalchia.gov.co
Teléfono: (57 1) 5951230
Línea de atención gratuita: (57) 1 5951230

CAD San Rafael
http://www.cadsanrafael.co
Vereda Fonqueta - Finca Ivon Luciany
Chía - Cundinamarca
Tel: (57 1) 8623090
    (57 1) 8638985
    (57) 315 3941616
    (57) 320 2941525

Doctoralia
https://www.doctoralia.co/clinicas/psiquiatria/chia

Item C. Contact information – English Version

Researcher's Contact Information

If you have any questions about the study, you may contact Veronica Felstad the primary investigator at (XXX) XXX-XXXX or via email at <u>vfelstad@antioch.edu</u>; Chris Heffner Dissertation Chair at <u>cheffner@antioch.edu</u>; Dana Waters Committee Member at <u>dwaters@antioch.edu</u>, or Juan Camilo Restrepo Committee Member at <u>juanreca@unisabana.edu.co.</u>

If you have any questions about your rights as a research participant, you may contact Dr. Mark Russell, Chair of the Antioch University Seattle IRB, at 206-268-4837 or via email at mrussell@antioch.edu.

Item D. Contact information – Spanish Version

Información de contacto del investigador

Si tiene alguna pregunta sobre el estudio, puede contactar a Veronica Felstad, la investigadora principal al (XXX) XXX-XXXX o por correo electrónico a vfelstad@antioch.edu; Director de tesis Chris Heffner al cheffner@antioch.edu; Miembro de comité Dana Waters al dwaters@antioch.edu, o miembro de comité en Bogotá Juan Camilo Restrepo al juanreca@unisabana.edu.co.

Si tiene alguna pregunta sobre sus derechos como participante en la investigación, puede comunicarse con el Dr. Mark Russell, Presidente del comité de Ética de la Universidad de Antioch en Seattle al 206-268-4837 o al mrussell@antioch.edu.

Appendix D:

Copyright Permissions

Dr. Mary E. Procidano hereby granted permission at no charge for the following materials to be used in the present dissertation proposal.

- Appendix XXX The Perceived Social Support family (PSS-fa) scale
- Appendix XXX The Perceived Social Support friends (PSS-fr) scale

ANTIOCH UNIVERSITY   Veronica Felstad ▮▮▮▮▮▮

Re: Social support screening permission for dissertation
1 message

Mary Procidano ▮▮▮▮▮▮   Tue, Jun 20, 2017 at 7:14 AM
To: Veronica Felstad ▮▮▮▮▮▮

Veronica,
You have my permission to use the measures in your dissertation.
Attached is a copy of a chapter that may be useful to you.
sincerely yours,
Mary Procidano

_____
Mary E. Procidano, Ph.D., ABPP
Board Certified in Clinical Psychology
Associate Professor
Psychology Department

The information and material contained in this email message are intended only for the use of the addressee. If you are not the intended recipient, then you are instructed not to disclose, copy or distribute this communication and you are instructed not to take any action with respect to it other than to immediately notify the sender and to delete the message from your system.

On Wed, May 3, 2017 at 7:25 PM, Veronica Felstad <vfelstad@antioch.edu> wrote:
Hi Dr. Procidano

My name is Veronica Felstad and I am currently pursuing a Psy.D. in Clinical Psychology at Antioch University Seattle in Seattle WA. I am currently working on my doctoral dissertation that looks at the effects of social support in therapy outcomes. I will be comparing two different cultures since I want to get a good look at the differences in social support in therapy between individualistic cultures and collectivistic cultures. I have chosen Seattle to represent the individual culture and Bogota, Colombia to represent the collectivistic culture.
In my research I came across your article titled **"Measures of Perceived Social Support From Friends and From Family: Three Validation Studies"** which looked at the PSS-fa and PSS-fr measures your created.

I would very much like your permission to use these measures as part of my dissertation. I will be administering these measures to psychotherapy clients. I found many articles that have used them and I feel they fit very well with my study. The validity of my study will increase if I incorporate a measure that has already been published and shown strong validity and reliability.

I also noted Kenneth Heller as the second author on this article and was wondering if you thought I should try to contact him to get as well or with your permission it would be enough.

I hope yo hear from you soon.

Thank you for your time.

ANTIOCH
UNIVERSITY   Veronica Felstad ▮▮▮▮▮▮▮▮▮

Re: Permission cont.
1 message

Mary Procidano [▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮]   Sat, Nov 17, 2018 at 8:03 PM
To: Veronica Felstad ▮▮▮▮▮▮▮▮▮▮▮▮
Cc: Domínguez Espinosa Alejandra del Carmen ▮▮▮▮▮▮▮▮▮▮▮▮▮▮

Hi Veronica,
this all seems pretty routine to me . Congratulations on your research!
sincerely,
M. Procidano
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Mary E. Procidano, Ph.D., ABPP
Associate Professor
Psychology Department
Dealy Hall 240
Fordham University
▮▮▮▮▮▮▮▮▮▮▮▮

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On Sat, Nov 17, 2018 at 9:03 PM Veronica Felstad ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮wrote:
Hello Dr. Procidano and Dr. Heller,

I know you have given me permission to use the PSS-fa and PSS-fr measures in y dissertation but I wanted to tell you exactly where my dissertation will be published in case that changes your permission parameters. My dissertation will be published electronically in the following places:

- ProQuest Dissertations and Theses Database, a print on demand publisher, http://www. proquest.com/products-services/pqdt.html
- OhioLINK Electronic Theses and Dissertations center, an open access archive, https://etd.ohiolink.edu
- AURA: Antioch University Repository and Archive, an open access archive, http://aura.antioch.edu

Please let me know if you have any questions or concerns. I look forward to hearing from you soon.
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Veronica Felstad
Clinical Psy.D. Student
Antioch Univerisity Seattle
2400 3rd Ave #200, Seattle, WA
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Dr. Alejandra Dominguez Espinosa hereby granted permission at no charge for the following materials to be used in the present dissertation proposal.

ANTIOCH UNIVERSITY

Veronica Felstad ▬▬▬▬▬▬

Re: Social support screening permission for dissertation
1 message

Domínguez Espinosa Alejandra del Carmen ▬▬▬▬▬▬▬▬▬▬   Fri, May 5, 2017 at 5:16 AM
To: Veronica Felstad ▬▬▬▬▬▬

Dear Veronica:
Thank you for your email and yes, you can use the scale for your study. I wish you all the best.
Best regards

Alejandra Dominguez

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Ms. Dominguez
My name is Veronica Felstad and I am currently pursuing a Psy.D. in Clinical Psychology at Antioch University Seattle in Seattle WA. I am currently working on my doctoral dissertation that looks at the effects of social support in therapy outcomes. I will be comparing two different cultures since I want to get a good look at the differences in social support in therapy between individualistic cultures and collectivistic cultures. I have chosen Seattle to represent the individual culture and Bogota, Colombia to represent the collectivistic culture. I am Colombian which explains why I am interested in Bogota to begin with.
In my research I came across your article titled "Validez concurrente de la versión mexicana de las escalas de Apoyo Social Percibido de la Familia y los Amigos (PSS-Fa y PSS-Fr)" which looked at the PSS-fa and PSS-fr measures Dr. Procidano created and introduced them into Spanish versions for the first time. I also noted Irene Salas Menotti from Colombia and Carolina Contreras Bravo from Mexico co-authored the article with you alongside Dr. Procidano. I have sent an email to Dr. Procidano in an attempt to get her permission to use these scales on my dissertation and now I am contacting you to ask for your permission to use the spanish version ones as well on my dissertation.

I will be administering these measures to psychotherapy clients. I found many articles that have used them and I feel they fit very well with my study. The validity of my study will increase if I incorporate a measure that has already been published and shown strong validity and reliability as well as having been translated already.

I hope yo hear from you soon.

Thank you for your time.

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Veronica Felstad
Clinical Psy.D Student