# What do you expect from psychological care? A qualitative study of depressed patients' expectations treated in mental healthcare settings

Ana Karina Zúñiga Caiseo,[1,2] Guillermo De la Parra,[2,3] Lucía Núñez,[2,4] Mariane Krause[2,4]

[1]School of Psychology, Adolfo Ibáñez University, Santiago; [2]Millennium Institute for Research in Depression and Personality (MIDAP), Santiago; [3]Department of Psychiatry, Medicine Faculty, Pontifical Catholic University of Chile, Santiago; [4]School of Psychology, Faculty of Social Sciences, Pontifical Catholic University of Chile, Santiago, Chile

Correspondence: Correspondence: Ana Karina Zúñiga Caiseo, School of Psychology, Adolfo Ibáñez University, Av. Diagonal Las Torres, 2640 Santiago, Chile; Millennium Institute for Research in Depression and Personality (MIDAP), Av. Vicuña Mackenna, 4860 Santiago, Chile.
E-mail: anakarina.zuniga@edu.uai.cl

Contributions: AKZ, GdP, conception and design of the study; AKZ, GdP, LN, analysis and interpretation of data; AKZ, GdP, LN, article draft; AKZ, GdP, LN, MK, critical revision for important intellectual content. All the authors read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Conflict of interest: the authors declare no potential conflict of interest.

Ethics approval and consent to participate: this research was approved by the Health Sciences Research Ethics Committee of the Pontificia Universidad Católica de Chile (ID: 180014001). Before being interviewed, patients signed an informed consent form to participate in the study and to authorize the use of anonymized data for future publications.

Consent for publication: informed consent was obtained from the participants of this study.

Availability of data and materials: the recorded and transcribed interviews are stored by the corresponding author.

Funding: this work was funded by the National Agency for Research and Development (ANID)/Scholarship Program/Doctorado Nacional/2016-21161490 and ANID Millennium Science Initiative/Millennium Institute for Research on Depression and Personality-MIDAP ICS13_005.

Acknowledgments: the authors thank the Mental Health Unit, San Joaquín Medical Center of the UC CHRISTUS Health Network, the Primary Health Care centers of the Reloncaví Health Service, and the patients who participated in this study.

Citation: Zúñiga Caiseo, A.K., De la Parra, G., Núñez, L., Krause, M., (2025). What do you expect from psychological care? A qualitative study of depressed patients' expectations treated in mental healthcare settings. *Research in Psychotherapy: Psychopathology, Process and Outcome, 28*(1), 839. doi: 10.4081/ripppo.2025.839

Received: 15 November 2024.
Accepted: 21 February 2025.

Publisher's note: all claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article or claim that may be made by its manufacturer is not guaranteed or endorsed by the publisher.


*Licensee PAGEPress, Italy*
*Research in Psychotherapy:*
*Psychopathology, Process and Outcome 2025; 28:839*
*doi:10.4081/ripppo.2025.839*



## ABSTRACT

Depression is one of the main reasons for seeking mental health services; however, few studies have focused on the perspective of depressed patients to understand what they expect from this instance. This study aims to develop a comprehensive model of patients' initial expectations regarding psychological treatment in mental health care settings. Semi-structured interviews were conducted with sixteen depressed adult patients referred to psychological care before their first session. Data was analyzed using grounded theory and consensual qualitative methods. Patients had expectations regarding the characteristics of psychological treatment, the psychologist, and changes. Patients expect psychological care to have a clear purpose and to last the time required until they feel better. They expect the psychologist to be an active and responsive professional. Regarding changes, patients expect to understand why they have depression, develop personal resources, and improve their self-esteem and mood. Facilitating factors (*e.g.*, preferences for psychological support over medical treatment) and hindering factors (*e.g.*, institutional constraints) were identified in achieving these expectations. Based on patients' expectations, a helping relationship that is more responsive to their needs is underlined. Therapeutic skills and contextual factors are key facilitating elements to meet these expectations. The findings discuss how addressing expectations can serve as input for delivering more satisfactory treatment to patients.

**Key words:** patients' expectations, depression, psychological care, qualitative methods.

## Introduction

Patients' expectations play a key role in treatment outcomes; specifically, the generation of hope and positive expectations is a critical factor in many forms of healing (Frank & Frank, 1991). According to the contextual model (Wampold, 2015), expectations are the second mechanism through which psychotherapy works, with the first being establishing the therapeutic relationship and the third being the specific components of psychotherapy. Patients often come to therapy feeling demoralized and holding beliefs that have not helped them cope with their problems. Therefore, psychotherapy presents an opportunity to develop more adaptive explanations and solutions (Wampold, 2015). The psychotherapist provides a rationale for treatment, which helps reinforce or induce patients' outcome expectations (Cuijpers *et al.*, 2019; Wampold, 2015).

Expectations have a small but significant positive effect size on treatment outcome (d=.36, p<.001) (Constantino *et al.*, 2018). Quantitative studies in depression treatment have shown positive expectations predict the probability of full recovery and improve the engagement with the process (Elkin, 1994; Meyer *et al.*, 2002; Sotsky *et al.*, 1991).

Expectations positively impact the development of the therapeutic alliance (Connolly Gibbons *et al.*, 2003; Constantino *et al.*, 2005; Rizvi *et al.*, 2000). Both the therapist and the patient must agree on therapeutic goals and tasks – two key components of the alliance – so that patients develop an expectation of change through therapeutic actions (Wampold, 2015). On the other hand, the alliance rupture negatively affects the outcome expectations. This negative impact was greater in patients who were skeptical at the start of therapy compared to those who had positive initial expectations of treatment (Westra *et al.*, 2011).

Patients' positive expectations regarding their treatment have been shown to increase the likelihood of a stronger treatment response (Vîslă *et al.*, 2018). For this reason, it is important for clinicians to be aware of their clients' outcome expectations and to have the skills needed to reverse negative expectations, thereby increasing hope (Seewald & Rief, 2023; Swift & Derthick, 2013). When addressing patients' expectations, light is shed on their understanding of problems: the explanations, representations, and beliefs that underlie them, as well as their hope (or not) about how treatment may help with their distress (Cuijpers, 2019; Greenberg *et al.*, 2006; Wampold, 2015).

In addition, it is important to consider whether expectations match patients' therapy experience. A study by Westra *et al.* (2010) demonstrated the importance of addressing the disconfirmation of expectations in psychotherapeutic treatments; they found that clients with good therapeutic outcomes were surprised because therapy had been collaborative, and patients could direct and trust their processes, achieving more than they expected; in contrast, those with negative outcomes were disappointed because their expectations were not fulfilled.

Depression is one of the main consultation reasons in mental health care centers (De la Parra *et al.*, 2021). There is concern about these patients' difficulties in complying with the offered treatments, which may affect the recurrence or chronicity of the disorder (Baune *et al.*, 2021; Demyttenaere *et al.*, 2019; Manning & Marr, 2003). Although studies are lacking, some differences have been observed in the fulfillment of expectations between patients in primary care and those in private care settings. For primary care users, the care experience can be more difficult and disappointing due to long waiting lists that limit opportunities for regular appointments with a professional, among other barriers (De la Parra *et al.*, 2019; De la Parra *et al.*, 2021; Owusu-Frimpong *et al.*, 2010; Toro-Devia & Leyton, 2023). Having a trust-based relationship with their provider, communicating in a way that aligns with patients' preferences, and being included in shared decision-making, are particularly valuable factors for primary care patients (Ashcroft *et al.*, 2020; Prins *et al.*, 2009) and these aspects are more likely to be found in private care (Owusu-Frimpong *et al.*, 2010; Toro-Devia & Leyton, 2023).

According to some authors, expectations are the common factor that has received the least attention in the research field (Greenberg *et al.*, 2006; Wampold, 2015; Weinberger & Eig, 1999; Westra *et al.*, 2010), even though evidence-based approaches recommend considering patients' preferences and expectations in treatment planning (APA, 2006; Mulder *et al.*, 2017). In research on the effectiveness of psychotherapy for depression, the patients' perspectives on the meaning of having depression, their treatment needs, and their opinions about how to resolve their problems have often been overlooked (Cuijpers, 2011). This shortcoming in depression research has been emphasized by various authors (*e.g.*, Chevance *et al.*, 2020; Ormel *et al.*, 2019; Prins *et al.*, 2009), and qualitative studies can help us understand in depth what patients expect from their treatment.

In this regard, one study highlighted the need for patients with depression for rapid relief of their symptoms (fatigue, lack of concentration, lack of motivation, sadness, and anxiety) and their dissatisfaction with pharmacotherapy in achieving this relief (Baune *et al.*, 2021). It has also been observed that clinicians and patients positively value changes that go beyond symptomatic alleviation, including the restoration of social and interpersonal relationships, the improvement of quality of life, and the pursuit of personal goals (Kan *et al.*, 2020).

Another qualitative study reporting how psychological care could be satisfactory for patients found that clinicians were expected to have empathetic listening skills, a unique understanding of their depression, and sensitivity to the impact of the stigma associated with the diagnosis. In contrast, clinicians feared opening "Pandora's box" by engaging in conversation and listening, and underestimated the role that patients' support networks could play (Keeley *et al.*, 2014). Finally, regarding adolescent patients, Weitkamp *et al.* (2017) identified four important topics to consider in the psychotherapeutic management of their expectations: being cautiously hopeful; seeing therapy as a long and challenging process in which they must deal with negative emotions or suppressed memories; viewing therapy as an opportunity to understand themselves; and wishing to find the "perfect" therapist for them. These expectations could likely be shared by others affected by this disorder as well.

Considering the clinical and empirical relevance of understanding patients' expectations to facilitate their treatment adherence, strengthen the therapeutic relationship, and ultimately improve therapy outcomes (Constantino *et al.*, 2018; Vîslă *et al.*, 2018; Wampold, 2015; Westra *et al.*, 2011; Weitkamp *et al.*, 2017), this paper explores and analyzes what depressed patients expect before they initiate psychological treatment in two mental health centers, a university outpatient clinic and a primary care center. The aim is to develop a theoretical model of patients' expectations based on their own perspective, shedding light on how a suitable treatment should be to meet patients' expectations.

## Methods

This study follows a qualitative design primarily based on grounded theory methods (Glaser & Strauss, 1967), which have been further developed and refined over time (Chapman *et al.*, 2015; Flick, 2018; Levitt, 2021; Strauss & Corbin, 2002). This methodology is adequate to develop knowledge regarding a less explored phenomenon and is well suited for generating theory based on participants' views, highlighting the subjectivities and the emergent phenomena resulting from data analysis (Chapman *et al.*, 2015; Creswell & Poth, 2018; Flick, 2018; Levitt, 2021). Strategies from consensual qualitative research (Hill *et al.*, 2005; Hill & Knox, 2021) were also used to carry out a cross-sectional analysis among participants to control for interpretation bias.

### Setting

This study took place in two outpatient mental health centers: one university outpatient clinic and the other a primary health care. The first center offers focused psychological care for a range of mental health disorders (but without a set limit on the number

of sessions) and low-cost psychiatric care. The university outpatient clinic[1] is often an alternative for part of the population that can afford lower-cost treatment to access specialized care (De la Parra *et al.*, 2018). Primary health care offers a free mental health program for a number of mental health disorders (including depression), with guaranteed coverage for time-limited psychological care, psychosocial support, and pharmacotherapy (Ministry of Health of the Government of Chile, 2013; 2017). In this setting, patients with depression are usually seen by a general practitioner or family physician and then referred to a psychologist, depending on the severity of the condition.

## Participants

Participants were recruited by convenience, considering accessibility criteria to participate in the study, such as having the willingness and time to participate in the interview before their first psychological session. Inclusion criteria were patients over 18 years old, awaiting psychological care in an institutional setting, and diagnosed with depression by a physician. Thirteen women and three men (N=16), between 21 and 58 years old (M=35.82, SD=12.39), all of them self-identified as Chilean (Latin American ethnicity) and from lower-middle socioeconomic strata, were recruited.

Theoretical sampling (Creswell & Poth, 2018; Flick, 2018) was used as a methodological strategy to recruit participants purposefully. This sampling consists of recruiting participants based on the emerging information from the preliminary analysis of the interviews. In the first instance, 10 patients were recruited from the university outpatient clinic. A preliminary analysis of these interviews revealed that 9 patients had received previous psychological treatment, and 60% of them shared their expectations based on prior experiences in primary health care. For this reason, it was decided to recruit patients from primary health care centers to explore their current expectations (n=6)

Nine individuals were receiving pharmacotherapy for depression. According to the MINI-International Neuropsychiatric Interview (Ferrando *et al.*, 2000), all participants met the criteria for major depressive episodes, eight of whom had recurrent depressive episodes with melancholic features, and twelve met the criteria for suicide risk (Table 1).

## Data collection

### *Semi-structured interviews*

The first author developed and piloted a semi-structured interview to explore patients' expectations in the framework of her doctoral dissertation. This interview covered two thematic axes: i) expectations regarding psychological treatment, aimed to explore how they would like the treatment to be, what tools or help they expected to find during psychological care, what would be a good treatment outcome for them, and how long they expected the treatment to last; ii) expectations about the characteristics of their future psychologist, exploring personal and professional traits and possible attitudes that they would like or not to find in the psychologist. Based on these axes, a script was developed, containing questions to initiate the conversation and build trust with the patient, and then the core exploration questions (Table 2).

### *Procedure*

The research team consisted of five researchers: three psychologists and postgraduate students with clinical experience who comprised the coding team and two experienced academic researchers who acted as independent supervisors of the research process. The principal researcher contacted the participants and arranged a face-to-face appointment before their first psychological session. During that appointment, the informed consent was signed, then instruments to verify their depression diagnosis and explore their depressive personality style and structural personality functioning were administered, and after a break, the in-depth interview was conducted, which lasted around 20 minutes. All interviews were audio-recorded and transcribed using Mergenthaler norms (Mergenthaler & Gril, 1996).

[1] Although the university outpatient clinic belongs to a private university, it serves a population belonging to the 4th to 9th income deciles (between 200 and 1000 dollars of individual income, family average), which represents approximately 60% of the Chilean population (De la Parra *et al.*, 2018).

**Table 1.** Participants characteristics (N=16).

| Characteristics | N | % |
|---|---|---|
| Gender | | |
| Female | 13 | 81.3 |
| Male | 3 | 18.7 |
| Undergoing pharmacotherapy | 9 | 56.3 |
| Previous psychological treatment in general[a] | 13 | 81.3 |
| Previous psychological treatment in public health care[b] | 10 | 62.5 |
| Depression diagnosis[c] | 16 | 100 |
| Recurrent major depressive episode | 8 | 50 |
| Major depressive episode with melancholic features | 8 | 50 |
| Suicide risk[d] | 12 | 75 |
| Mild risk | 7 | 43.8 |
| Moderate risk | 3 | 18.8 |
| High risk | 2 | 12.5 |

Participants were on average 35.82 years old (SD=12.39); [a]number and percentage of participants answering "yes" to this question; [b]number and percentage of participants answering they had consulted the public health system to treat their depression before; [c,d]results of application of MINI International Neuropsychiatric Interview (Ferrando *et al.*, 2000) to confirm depression diagnosis and suicide risk.

## Data analysis

The analysis units were 16 semi-structured interviews. The study was carried out in an iterative process of open, axial, and selective coding (Chapman *et al.*, 2015; Corbin & Strauss, 1990) supported by Atlas Ti v8. Open coding involved comparing data with data, line with line of each interview, in a well-structured analytical process where researchers explored the meanings that emerge from the text, developing codes (Flick, 2018). In this process, it was useful to contrast the interpretation of the data with the guiding question: What are the participants saying about their expectations? Axial coding followed and entailed a connector analysis of the codes that emerged in the initial open coding. The aim was to establish groups of categories organized into core categories and better identify the relationships between them (Benaquisto, 2008; Flick, 2018). Selective coding involved identifying the most relevant categories from a substantial amount of data, aligned with the objectives of the study. This process also considered theoretical saturation, which is the stage at which no new properties or dimensions emerge, despite the variability in the data (Corbin & Strauss, 1990; Flick, 2018).

### *Integrity and trustworthiness of qualitative analyses*

Three strategies were employed to control any possible interpretation biases: triangulation and consensus, the nomenclature of frequencies derived from the consensual qualitative research model (CQR), and a stability check (Hill *et al.*, 2005; Hill & Knox, 2021).

The researchers' impressions of the data analysis and interpretation were triangulated to reach consensus through intersubjective agreement (Altimir *et al.*, 2017; Hill & Knox, 2021). Triangulations were also carried out with external researchers, with a constant comparison between domains, emergent categories, and core ideas (Hill & Knox, 2021). When data was not clear enough to code, participants were contacted to clarify the content of their statements.

The nomenclature advanced by Hill *et al.* (2005) in the CQR to report the frequency of each category was employed to perform an accurate comparison of the significant contents, striving not to overestimate contents that might have been too idiosyncratic. "General" refers to categories that appeared in all participants or all except for 1; "typical" refers to categories that appear in more than half the participants; "variant" is for categories that appear in half the participants or fewer; and "rare" is for categories that appear in 2 or 3 participants (Hill *et al.*, 2005). The stability check was carried out, leaving one interview out of the set of interviews analyzed, and it was found that the coding of this last interview did not lead to substantial changes in terms of the appearance of new categories or the frequencies assigned (*e.g.*, "general", "typical") to existing categories.

## Ethical considerations

This research was approved by the Health Sciences Research Ethics Committee of the Pontificia Universidad Católica de Chile, ID: 180014001. Before being interviewed, patients signed an informed consent form to participate in the study and to authorize the use of anonymized data for future publications.

# Results

Three core categories of expectations emerged and were organized in: treatment characteristics, psychologist characteristics, and change (Figure 1). Regarding the treatment characteristics, patients expected that it would not be just "going on and on" without understanding why. In terms of extent, they expected the therapy to last long enough to make them feel better. As a facilitating factor for positive expectations of psychological care, participants had a preference for psychological treatment over solely pharmacological medical treatment, as they wanted a space to talk and understand what was happening to them, that lasted longer than the brief medical consultation.

Participants' expectations of the psychologist's characteristics denoted meeting a therapist who, on a professional level, had a strong vocation and was proactive and, on an interpersonal level, could be receptive, welcoming, and committed to bonding with the patient. The facilitator of this category was the need to share what was happening to them with a trained professional, which predisposed patients to want to meet a therapist who was welcoming and engaged with them.

Expectations for change were composed of achieving a better understanding of "why do I have depression", learning to manage negative emotions, improving self-esteem, and preventing emotional crises by developing personal resources. A facilitator that predisposed patients to have these change expectations was the faith that psychological therapy would be effective.

As mentioned before, a large proportion of the sample (13 out of 16 participants) had received previous experiences with psychological treatment in public mental health centers (10 participants) and in private clinics (3 participants). Participants tended to mention their expectations, considering their past negative experiences. For example, patients who had previously negative experiences in primary care and were now seeking a new treatment opportunity at the university clinic cited the limitation of not receiving extended therapy over time – or until they felt better – as a barrier to meeting their change expectations. In addition, previ-

**Table 2.** Semi-structured interview: topics and examples of open-ended questions.

| Interview topics | Examples of open-ended questions |
|---|---|
| Explore expectations and needs regarding psychological care and how to be helped | What do you expect from psychological care?<br>What would you like to reach with psychological care?<br>What kind of tools or help could relieve your discomfort?<br>What would you like to see happen in the psychological treatment?<br>How long would you like your psychological treatment or psychotherapy to last? |
| Explore expectations about the psychologist | What would you like your psychologist to be like?<br>What do you expect from your psychologist to relieve your depression or problems?<br>How would you like your psychologist to behave towards you?<br>What attitudes would you like to see in him or her? |

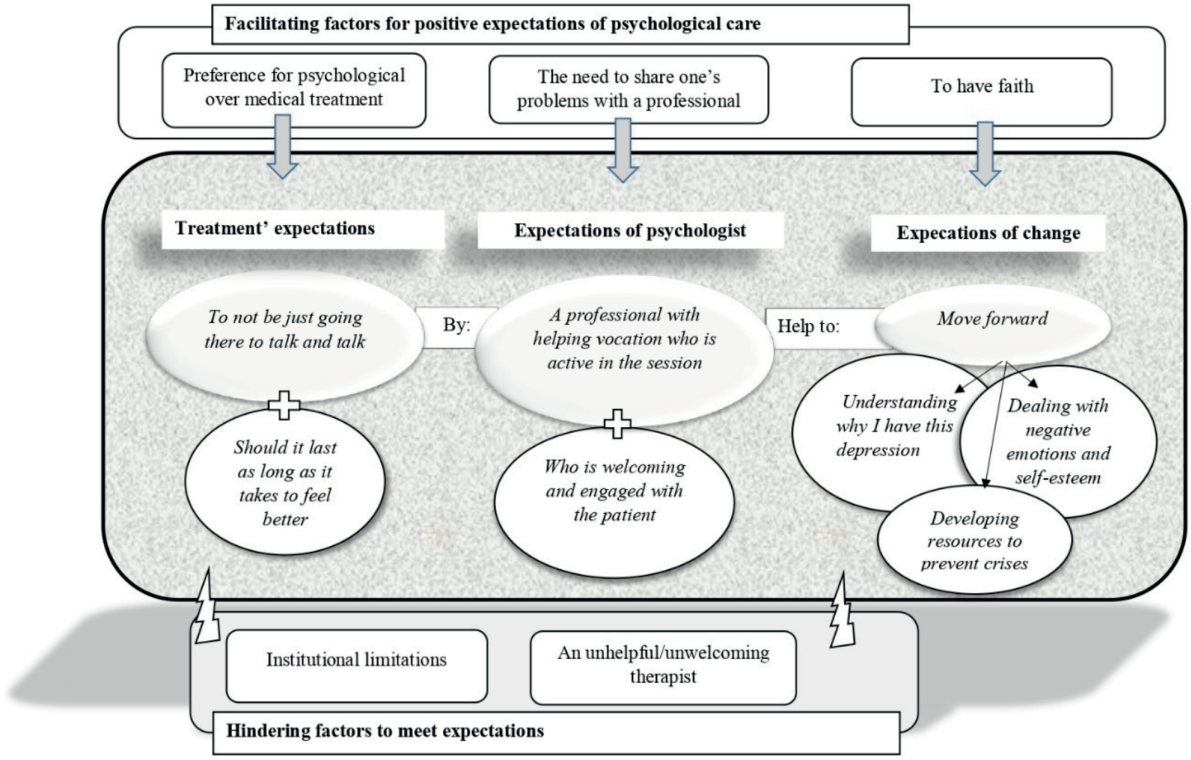


**Figure 1.** Proposal for an emerging phenomenon of patients' expectations.

ous experiences with a therapist who did not receive them in a welcoming way or proved to be of little help with their depression were an expectation hindrance. Therefore, institutional and therapists' limitations were seen as obstacles to meeting patients' positive expectations of treatment, therapist, and change.

## What do patients expect from psychological care?

### *Psychological care as a meaningful conversation: "Not just going there to talk and talk"*

When asked about treatment expectations, patients typically expected to feel that in the conversation with the psychologist, an effort was being made to help them better understand what they are going through and not just merely talking. When asked about the expectations of how the psychologist could help with the depression, a young woman answered based on her dissatisfaction with past therapy experiences:

> "More than just talking and having conversations... maybe there's something that can help me understand... the thing is, I used to talk and talk to my previous psychologist, but she gave me nothing in return [...]. Sometimes just having a clear idea, like 'What's the point of this thing you're asking me?' because you go there (to therapy), talk and talk... and have no idea how that's helping you" (Patient 8).

### *Psychological care as a complete process: "I want to stay as long as it takes to feel better"*

Regarding the expected extent of therapy, patients typically expressed that it should last as long as it takes them to feel better. Patients who had previously been treated in institutional settings knew that therapy was likely to last only a few sessions, as they had experienced being discharged or referred to a higher level of care earlier than they would have expected. A patient who sought care at the university clinic illustrates this expectation: "I hope it will last for a while! As long as it's necessary for me to feel better. When I can say to myself: 'I don't need to talk to you anymore', I'm leaving (laughs)" (Patient 7).

## What do you expect from your psychologist?

### *At the professional level: "I expect a professional with a helping vocation, who is active in session"*

In terms of traits of the psychologist, patients typically expected a professional with a helping vocation. In the words of one patient, "if the psychologist does not have a vocation, he/she will never get to the bottom of the problem" (Patient 5). Related to this category, some patients also highlighted that the psychologist should be up to date in terms of knowledge (variant) and should be responsible for the agreed schedule (not canceling sessions without warning) and the extension of sessions (not closing them before the set time) (variant). Psychologists' failure to fulfill these responsibilities was interpreted as a lack of consideration for the other.

In addition, patients expected the psychologist to be active in terms of his/her performance in session. Patients typically stressed that the psychologist should be an active listener and remember the previously addressed topics. A patient reflects on this subject: "I want the psychologist to listen to me actively, I feel it's very important because I notice it in the details that... later on, like in the next sessions, he remembers the things I said" (Patient 9).

The patients typically stated their desire for the therapist to be actively searching for a solution to their problems, offering ad-

vice and guidance. This is pointed out by a man who was about to receive psychological care for the first time in his life: "More than support, I want him to advise me, not so much on how to take decisions, but to tell me, 'Look, you need to deal with this problem, and you need to do so in this way'" (Patient 14).

Typically, patients expected the therapist to conduct interactive tasks, including questionnaires, homework, surveys, or other activities to allow them to better understand themselves or their problems. This hope is voiced by a patient:

> "I'd like something more... I don't know if the word is play-based, but, for instance, that through certain exercises or a game we could draw conclusions, for example. Maybe I could answer a survey on something, and based on that, we have a discussion, 'Look, you're saying this... so... why did you answer this?' That sort of stuff" (Patient 9).

This excerpt shows how the patient illustrates the therapist's voice, taking advantage of the task to draw conclusions. This therapist's action of ensuring that the patient walks out of the office with significant insight, based on a conversation or activity, was typically expected by the patients, as exemplified by another participant:

> "If the psychologist can make me discover something new... and go home with an idea... with something in my head... with a clear insight, even if it's a new question... if the psychologist manages that in a session, I think... that's going to turn into something important!" (Patient 6).

Patients expected the psychologist to help them see things from new perspectives (variant). The ability to ask questions enables them to gain a better understanding of what is happening to them (linked to their change expectations) and this aspect was also pointed out by some patients (variant):

> "I'd like him to ask questions that allow me to detect what the problem is, questions that are, like, the right questions, because... I don't know how to ask myself those questions. And, when he asks me those questions, maybe I could solve or discover what happened in my life" (Patient 6).

The previous quotations stress that the psychologist's ability to be active in the session is strongly associated with creating a conversation that has a meaning, a direction.

### *At the interpersonal level: "a professional who is welcoming and engaged"*

As for the interactional style of the therapist, in general, patients stressed that he/she should be welcoming, and other interpersonal qualities were related to this category. Typically, the patients appreciated a close and warm attitude in the therapist, even stating that they expected him/her to be like their "partner". Likewise, the therapist was typically expected to inspire trust and safety and to be kind and friendly (variant). Some of the core ideas of what it means to be welcoming (receptive function of the therapist) are illustrated by a patient in this quote: "I'd like psychologists to be kind, like that you can feel that she or he is welcoming you... should be friendly, the psychologist should know how to earn your trust" (Patient 3).

Having a non-critical stance (variant), in the words of patient 1: "I don't want him or her to raise an eyebrow if I say something outrageous", makes it easier for patients to feel welcomed by the future therapist.

Patients typically expect to see an engaged person who is involved at a more affective level. This means that the therapist must be empathetic, putting themselves in the patient's shoes (typical), showing an interest in what is happening to the patient (typical), along with being emotionally attuned (variant). The following patient illustrates these categories: "The psychologist should learn to understand the patient, put himself in the patient's shoes, feel what they're feeling. That's like the main difference between a good and a bad psychologist... they should be engaged with the patient" (Patient 7).

## What do you expect to achieve with psychological care?

### *To move forward: "Understanding why I have this depression, developing resources, and dealing with negative emotions and negative self-esteem"*

In general, patients expressed their desire for change as "moving forward", which meant being able to achieve a better understanding of why they had depression. They typically expected to discover aspects of themselves related to their problems, develop resources to prevent new crises, learn to deal with their negative emotions, and improve their self-esteem.

Understanding themselves and finding out in-depth "why I have this depression" were typically mentioned by the patients. An adult woman who had been treated pharmacologically during 15 years in primary care, expressed this expectation: "I want the psychologist to find out why I have this depression and this anguish that I don't know how to define. I want the psychologist to look into me until I know why I have this misfortune" (Patient 10).

Regarding the expectations to develop more personal resources to prevent crises, patients typically expressed the need to gain *tools* to deal with critical situations. A woman who was again seeking help at the university clinic due to a new depressive episode, expressed this desire:

> "I want to move forward... discover tools in me in case something similar happens to me. For example, I lost my mom four years ago, I'm going to lose my dad due to the law of life, or maybe I'll go first... I'm going to lose him at some point. So, I need weapons to cope when I experience losses, failures, to deal with all the negative things in life" (Patient 1).

Another typically expected change in patients was to be able to deal with negative emotions. This is illustrated by a patient as: "I'd like to try to control my emotions, like... if I'm crying, try to soothe myself so the crisis will go away sooner" (Patient 7).

Finally, improving their self-esteem was another expectation. Patients typically reported that high self-criticism, or accepting "humiliations or being underappreciated by others", affected their self-esteem, which they wanted to improve. Patient 9 noted: "I'm self-critical and have low self-esteem. I'd really like to love myself a little more".

### Facilitating factors for positive expectations of psychological care

Three typical facilitators for positive psychological care expectations were identified in patients' narratives. These included: i) preference for psychological over medical treatments, which predisposes to having expectations of meaningful psychological care; ii) the need to share one's problems with a professional, which leads to the desire to meet a psychologist able to help and welcome them; and iii) to have faith in moving forward, which makes people have a positive expectation of change.

Regarding the preference for psychological care, Patient 10 expressed:

> "I prefer a psychologist to a psychiatrist, because, I mean, I don't really understand what depression is like, but... um... the psychologist is going to listen to me and advise me, and the psychiatrist will just give me some pills. And I don't want that" (Patient 10).

The patients generally expressed a positive attitude toward discussing their problems with the psychologist, because their issues could not always be shared with a friend, as they could not disclose to someone in their intimate circle, or as they required more specialized listening. This is illustrated by patient 4, an adult woman with prior experiences in clinics: "You need to go to therapy, talk to someone who doesn't know you, talk to a professional".

Frequently, despite their depression, the patients felt hopeful to move forward. This faith is often expressed with optimism regarding the initiation of therapy, as expressed by patient 3: "I come with so much faith that I really... I'm going to move forward!".

### Hindering factors to meet expectations

As mentioned before, most of the patients included in this sample had previous mental health treatment experiences. Two factors that might discourage patients from achieving what they expected from psychological care were identified in these cases.

The first concern was the institutional limitations (variant), such as restrictions on treatment length, a lack of depression specialists in primary care (variant), or the high turnover of employees, which threatened the continuity of the therapeutic process (variant).

According to the experience reported by some patients who sought help in primary care facilities, it was frustrating to have been seen by a psychologist who was not a specialist in depression treatment and could not help them; in the end, they were referred to another mental health service, as reported by patient 2:

> [Interviewer: "Why are you seeking for treatment here (university clinic)?"] "Because the primary care psychologist didn't know how to treat me, so she referred me to another service. However, I couldn't continue the treatment in this second place [another Public Health Center] because it offered a limited number of sessions, and I got all of them. That's why I'm here." [Interviewer: "How did you feel about being referred somewhere else the first time?"] "I got frustrated because she (the psychologist) couldn't help me with anything, I wasted my time with her" (Patient 2).

## Discussion

This study aimed to develop an in-depth exploration of the expectations of depressed patients regarding the psychological care they were about to receive in a mental health center. Patients had expectations regarding the characteristics of psychological care, the psychologist, and changes.

Concerning patients' expectations of psychological care, their willingness to go to therapy for "as long as it takes to feel better" highlights their desire for a successful treatment without a predefined time limit. Chilean patients in primary care can wait up to two months between sessions, and there is no guarantee they will see the same professional from one session to another (De la Parra *et al.*, 2019; Toro-Devia & Leyton, 2023). In this study, half of the patients who visited the university clinic came from primary care and sought more specialized care. Furthermore, this desire and willingness to stay in therapy until they recover from their depression was confirmed by patients recruited in primary care. Our participants revealed that institutional barriers to providing psychological treatment in primary care may make it more difficult to meet patients' psychological care expectations and set a precedent for consulting one professional after another, posing significant risks to depressive patients if the disorder worsens. Furthermore, if patients' attempts to seek help fail, they may become even more desperate and hopeless, leading to an increased risk of suicide (Hawton *et al.*, 2013).

The expectation of being in therapy as long as it takes to feel better may link to the relational expectations of having a therapist who empathically welcomes and stays with the patient through treatment, as indicated in the literature (Ashcroft *et al.*, 2020; Keeley *et al.*, 2014; Prins *et al.*, 2009). As mentioned, some patients had previous negative experiences with therapists that were seen as unhelpful. Patients probably longed for a reparative emotional experience (Gunderson & Links, 2014) that the institution or therapist could not provide.

Concerning the expectations of the treating psychologist, patients appreciated the possibility of speaking with a professional about what they were going through and expected that the dialogue had a clear purpose for them. This is closely related to the expectation that psychological care will be conducted by a psychologist who is active in the session and will effectively help the patient move forward. In this sense, creating space for active listening and knowing how to guide the dialogue toward a therapeutic purpose that helps patients alleviate their symptoms (such as understanding what is happening to them, learning tools for self-regulation, *etc.*) seems essential in the approach to depression and is aligned with studies on patients' expectations and the ability of therapists to incorporate these expectations into treatment (Keeley *et al.*, 2014; Vîslă *et al.*, 2018; Westra *et al.*, 2011).

Our findings match those reported by Weitkamp *et al.* (2017), as patients hoped to get *a therapist who is perfect for them*. What perfect meant to the participants in this study was the expectation of receiving structured treatment that addressed their needs, as evidenced by the types of interventions they expected the psychologist to implement: "give me an opinion", "remember what we worked on", and "identify the problem and tell me how to solve it". Patients were looking for an active therapist with the necessary professional competencies to ensure they could draw something meaningful from the session. This result confirms the finding that a non-proactive therapist was an obstacle to effective treatment (Van Grieken *et al.*, 2014).

Depression is an individual emotional response to feelings of

loss or failure to achieve a desired state (Luyten & Blatt, 2012). In this context, an engaged therapist can provide the patient with emotional support, potentially filling the emotional void resulting from the loss or lack of significant figures. Furthermore, the active disposition of the therapist in achieving the changes that patients are not able to achieve on their own can be curative by instilling hope, as noted in the patients interviewed.

Also, patients described expecting interpersonal competencies in the therapist that they deemed important for constructing a positive therapeutic bond, such as being welcoming, warm, likable, inspiring trust, showing interest, being empathetic, being engaged with the patient, and non-critical. Some of these qualities, such as empathy and positive regard, have been classed as *common therapist skills* (Anderson *et al.*, 2015) or *contextual model factors* (Wampold, 2015) and have been highlighted or desired by patients in other studies (Altimir *et al.*, 2017; Ashcroft *et al.*, 2020; Seewald & Rief, 2023; Van Grieken *et al.*, 2014; Weitkamp *et al.*, 2017). This emphasis made by participants on a patient-oriented stance may reflect a deep desire for the therapist to keep them in mind and offer a helping relationship informed by a person-centered rather than a disorder-centered approach (Gunderson & Links, 2014).

It is important to bear in mind that the training received by many psychologists in Chile is of the private practice type (De la Parra *et al.*, 2018), where, especially in the psychoanalytic tradition, neutrality and abstinence are favored, which contravenes what patients look for, and therefore is consistent with the frustration of patients when sessions lack feedback and are "just talking and talking".

Expecting sessions to be purposeful, guided by an active therapist, and the therapist to be welcoming and engaged with the patient alludes to three components of the therapeutic alliance: goal agreement, task agreement, and bonding (Bordin, 1979). Interestingly, patients unknowingly expect to encounter essential aspects of the therapeutic alliance in their psychological care, which underscores the importance of considering these aspects throughout treatment to ensure the mechanisms by which therapy is effective (Wampold, 2015).

The positive impact of patients' willingness to discuss their problems with a professional, together with the expectation of understanding *why I have depression*, confirms how relevant it is for the therapist's attitude regarding the management of the disorder to be consistent with the patient's views on the etiology of his/her depression and how to treat it (Blatt *et al.*, 1996; Keeley *et al.*, 2014; OPD-2 Task Force, 2008; Van Schaik *et al.*, 2004), which would also strengthen the therapeutic alliance (Altimir *et al.*, 2017; Wampold, 2015).

On the other hand, it has been found that, in primary care, patients often prefer to talk to a professional psychologist about their problem rather than just being treated with medication (Bosman *et al.*, 2008; Johnston *et al.*, 2007; Van Shaik, 2004). This preference was also observed in our participants. This finding may be very relevant to medical professionals who are usually the first line of care and thus can approach the patient with depression from a more comprehensive perspective, which may be useful in preventing relapse due to the frequent discontinuation of pharmacological treatment that patients with depression present (Demyttenaere *et al.*, 2019; Keeley *et al.*, 2014; Manning & Marr, 2003; Ormel *et al.*, 2019).

Considering patients' change expectations, in this study, they generally expected positive changes due to psychological care. They refer to these changes as *moving forward*, which involves discovering why they have depression, improving their way of coping with negative emotions and self-esteem issues, and developing personal resources to prevent new crises. Some of the achievement expectations align with prior research regarding the treatment of depression, where patients appreciated the reduction in mood symptoms and mental pain (Chevance *et al.*, 2020), finding new ways of functioning that enabled them to navigate the circumstances they faced, preventing relapses, and accepting depression as part of life to keep going (Kan *et al.*, 2020).

Although some patients had negative previous psychotherapeutic experiences, all of them expected to improve after the current process, which is a good starting point to ensure successful treatment (Constantino *et al.*, 2018; Meyer *et al.*, 2002). This hopeful approach contrasts with patients' hopeless attitude before starting therapy, as reported in the literature (Beck *et al.*, 2012; Weitkamp *et al.*, 2017). Therapists must be prepared to deal with the mood swings of patients and adequately reward the hope that they place in psychological help (Beck *et al.*, 2012; Frank & Frank, 1991). Being responsive to patients' faith and considering addressing hope in treatment appear to be important therapeutic skills for treating depressed patients (Seewald & Rief, 2023; Swift & Derthick, 2013).

It is interesting to note that patients' expectations to understand why they are depressed and acquire tools to cope with emotional dysregulation and self-esteem issues, seem to articulate perfectly with the expressive-supportive continuum proposed by the psychodynamic perspective (Leichsering & Schauenburg, 2014). Thus, the expressive pole seeks to understand what is behind it, searching for the meaning of depression, which may involve a therapeutic process containing painful insights. The supportive pole seeks (from a relational point of view) to provide resources to support the functioning of the personality structure in the areas of self-esteem and emotional regulation (Leichsering & Schauenburg, 2014; OPD Task Force, 2008).

In short, we are talking about patients expecting to find a therapist who is basically committed, active, connected, warm, and concerned that the patient "leaves with something" after each session and who accompanies them in a process that involves understanding their condition and acquiring tools to regulate their emotions and self-esteem. Having an in-depth understanding of the expectations of patients with depression provides valuable insight into how to care for them and where to focus treatment goals, all while maintaining their perspective. According to the reviewed literature, this approach would strengthen the therapeutic alliance and predict positive treatment outcomes.

## Limitations and future research directions

Although these findings generated valuable information to understand pre-treatment expectations of depressed patients from a first-person view, these should be considered preliminary findings. Large-scale studies are required to compare convergences and divergences in treatment and therapist expectations before and at the end of the therapeutic processes, and it would be interesting to explore their association with improvement, therapeutic alliance, and treatment satisfaction.

The present study confirms the assumption that psychologists play a fundamental role in precarious care settings, such as primary care, in providing care tailored to the preferences of patients who expect more psychotherapeutic than pharmacological management of their depression (Van Schaik *et al.*, 2004).

Although the World Bank considers Chile a high-income country (https://data.worldbank.org/country/chile), the population

has significant inequalities, especially in access to high-quality healthcare (Toro-Devia & Leyton, 2023). We assume that there are no major differences in the expectations phenomenon between the users interviewed at the primary health care and the university clinic, but a limitation of this study is that it cannot be established empirically. At the same time, it must be taken into account that the users of the university clinic pay a low fee for treatment, but those of the primary health care do not pay at all and may belong to more vulnerable sectors. Future studies, with larger samples, will be able to address the specific question regarding expectations of treatment and income levels. In any case, we believe that the ideas presented here are relevant for sensitizing mental health professionals to the importance of considering patients' expectations of care, as well as expectations regarding professional and therapeutic changes, both in Latin American countries and in other contexts with higher standards of living.

## Conclusions

Exploring what depressive patients expect from their psychological treatment yielded relevant information about patients' needs and the factors that can facilitate or hinder access to satisfactory treatment. The findings from this study suggest redirecting the therapeutic work towards the fulfillment of patients' expectations that could be associated with real relief, such as supporting them to understand their distress, giving concrete tools to deal with their depression, and being able to offer a helping relationship where the therapist is receptive and active in finding solutions.

The emerging theory on patient expectations discussed in this work can assist therapists working in mental health services with limited resources by broadening their understanding of depressed patients' perspectives. It can help deconstruct the stigmatization associated with the disorder and guide therapists in implementing clinical strategies that incorporate the patient's perspective throughout the treatment process.

## References

Altimir, C., Capella, C., Núñez, L., Abarzúa, M., & Krause, M. (2017). Meeting in difference: Revisiting the therapeutic relationship based on patients' and therapists' experiences in several clinical contexts. *Journal of clinical psychology, 73*(11), 1510–1522. doi: 10.1002/jclp.22525

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. doi: 10.1037/0003-066X.61.4.271

Anderson, T., Crowley, M. E., Himawan, L., Holmberg, J. K., & Uhlin, B. D. (2015). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy research: journal of the Society for Psychotherapy Research*, *26*(5), 511–529. doi: 10.1080/10503307.2015.1049671

Ashcroft, R., Menear, M., Greenblatt, A., Silveira, J., Dahrouge, S., Sunderji, N., Emode, M., Booton, J., Muchenje, M., Cooper, R., Haughton, A., & McKenzie, K. (2021). Patient perspectives on quality of care for depression and anxiety in primary health care teams: A qualitative study. *Health expectations: an international journal of public participation in health care and health policy*. doi: 10.1111/hex.13242

Baune, B.T., Florea, I., Ebert, B., Touya, M., Ettrup, A., Hadi, M., & Ren, H. (2021) Patient Expectations and Experiences of Antidepressant Therapy for Major Depressive Disorder: A Qualitative Study. *Neuropsychiatric Disease and Treatment, 17*, 2995-3006. doi: 10.2147/NDT.S325954

Beck, A., Rush, J., Shaw, B., & Emery, G. (2012). *Terapia Cognitiva de la Depresión* [Cognitive Therapy of Depression] (20th ed.). Desclée de Brouwer.

Benaquisto, L. (2008). Axial coding. In L. M. Given (Ed.), *The Sage encyclopedia of qualitative research methods* (Vol. 1, pp. 51-52). Thousand Oaks, CA: SAGE.

Blatt, S. J., Quinlan, D. M., Zuroff, D. C., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of consulting and clinical psychology*, *64*(1), 162–171. doi: 10.1037//0022-006x.64.1.162

Blatt, S. J., D'Afflitti, J. P., & Quinlan, D. M. (1976). Experiences of depression in normal young adults. *Journal of Abnormal Psychology, 85*, 383-389. doi: 10.1037/0021-843X.85.4.383

Bordin, E. S. (1979). The generalizablity of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, *16*, 252–260.

Bosmans, J. E., van Schaik, D. J., de Bruijne, M. C., van Hout, H. P., van Marwijk, H. W., van Tulder, M. W., & Stalman, W. A. (2008). Are psychological treatments for depression in primary care cost-effective?. *The journal of mental health policy and economics*, *11*(1), 3–15.

Callahan, J. L., Gustafson, S. A., Misner, J. B., Paprocki, C. M., Sauer, E. M., Saules, K. K., Schwartz, J. L., Swift, J. K., Whiteside, D. M., Wierda, K. E., & Wise, E. H. (2014). Introducing the association of psychology training clinics' collaborative research network: A study on client expectancies. *Training and Education in Professional Psychology, 8*(2), 95–104. doi: 10.1037/tep0000047

Chapman, A. L., Hadfield, M., & Chapman, C. J. (2015). Qualitative research in healthcare: an introduction to grounded theory using thematic analysis. *The journal of the Royal College of Physicians of Edinburgh, 45*(3), 201–205. doi: 10.4997/JRCPE.2015.305

Chevance, A., Ravaud, P., Tomlinson, A., Le Berre, C., Teufer, B., Touboul, S., Fried, E., Gartlehner, G., Cipriani, A., & Tri Than, V. (2020). Identifying outcomes for depression that matter to patients, informal caregivers, and health-care professionals: qualitative content analysis of a large international online survey. *Lancet Psychiatry, 7*, 692-702. doi: 10.1016/S2215-0366(20)30191-7

Connolly Gibbons, M. B., Crits-Christoph, P., de la Cruz, C., Barber, J. P., Siqueland, L., & Gladis, M. (2003). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive-expressive psychotherapy and cognitive therapy. *Psychotherapy Research*, *13*(1), 59–76. doi: 10.1093/ptr/kpg007

Constantino, M. J., Vîslă, A., Coyne, A. E., & Boswell, J. F. (2018). A meta-analysis of the association between patients' early treatment outcome expectation and their posttreatment outcomes. *Psychotherapy*, *55*(4), 473-485. doi: 10.1037/pst0000169

Constantino, M. J., Arnow, B. A., Blasey, C., & Agras, W. S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of consulting*

*and clinical psychology*, *73*(2), 203–211. doi: 10.1037/0022-006X.73.2.203

Creswell, J. & Poth, C. (2018). *Qualitative Inquiry and Research Design, Choosing Among Five Approaches* (4th Ed.). SAGE.

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcome. *Annual Review of Clinical Psychology*, *15*, 207-231. doi: 10.1146/annurev-clinpsy-050718-095424

Cuijpers, P. (2011). The patient perspective in research on major depression. *BMC Psychiatry*, *11*(89), 1-2. doi: 10.1186/1471-244X-11-89

De la Parra, G., Zúñiga, A.K., Gómez-Barris, E., & Dagnino, P. (2021). Complex depression in high-pressure care settings: strategies and therapeutic competences. De la Parra, G., Dagnino, P., Bhen, A. Eds. In: *Depression and Personality Dysfunction: An Integrative Functional Domains Perspective*, 213-244, Springer Nature.

De la Parra, G., Errazuriz, P., Gomez-Barris, E., & Zúñiga, A.K. (2019). Propuesta para una psicoterapia efectiva en atención primaria: un modelo basado en la experiencia y la evidencia empírica [A proposal for effective psychotherapy in primary care: a model based on experience and empirical evidence] *Temas de la Agenda Pública, 14*(113), 1-20. Available from: https://politicaspublicas.uc.cl/publicacion/propuesta-para-una-psicoterapia-efectiva-en-atencion-primaria-un-modelo-basado-en-la-experiencia-y-evidencia-empirica/

De la Parra, G., Gómez-Barris, E., Zúñiga, A., Dagnino, P., & Valdés, C. (2018). From the "couch" to the outpatient clinic: a model of psychotherapy for institutions. Learning from (empirical) experience. *Revista Argentina de Clínica Psicológica, 27*(2), 182-202. doi: 10.24205/03276716.2018.1057

De la Parra, G., Dagnino, P., Valdés, C., & Krause, M. (2017). Beyond self-criticism and dependency: structural functioning of depressive patients and its treatment. *Research in Psychotherapy: Psychopathology, Process and Outcome, 20*, 43–52. doi: 10.4081/ripppo.2017.236

Demyttenaere, K., Frank, E., Castle, D., & Cindik-Herbrüggen, E. (2019). Integrating Patients' Expectations into the Management of Their Depression: Report of a Symposium at the European College of Neuropsychopharmacology Congress. *Advances in therapy*, *36*(3), 73–90. doi: 10.1007/s12325-019-01038w

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 114–149). John Wiley & Sons.

Flick, U. (2018). *The SAGE Handbook of Qualitative Data Analysis*. SAGE Publications Ltd.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Johns Hopkins University Press.

Ehrenthal, J. C., Dinger, U., Horsch, L., Komo-Lang, M., Klinkerfuß, M., Grande, T., Schauenburg, H. (2012) Der OPD-Strukturfragebogen (OPD-SF): Erste Ergebnisse zu Reliabilität und Validität. *Psychotherapie Psychosomatik Medizinische Psychologie*, *62*, 25-32. doi: 10.1055/s-0031-1295481

Ferrando, L., Bobes, J. Gibert, S., Soto, M., & Soto, O. (2000). *Mini International Neuropsychiatric Interview (M.I.N.I)*, versión en español 5.0.0. Instituto IAP.

Glasser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory.* Aldine Publishing Company.

Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clinical Psychology Review*, *26*(6), 657-678. doi: 10.1016/j.cpr.2005.03.002

Gunderson, J. G., & Links, P. (Collaborator). (2014). *Handbook of good psychiatric management for borderline personality disorder*. American Psychiatric Publishing, Inc.

Hawton, K., Casañas, I., Comabella, C., Haw, C., & Saunders, K. (2013). Risk factors for suicide in individuals with depression: a systematic review. *Journal of affective disorders, 147*(1-3), 17–28. doi: 10.1016/j.jad.2013.01.004

Hill, C. & Knox, S. (2021). *Essentials of consensual qualitative research.* American Psychological Association. doi: 10.1037/0000215-000

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*(2), 196–205. doi: 10.1037/0022-0167.52.2.196

Johnston, O., Kumar, S., Kendall, K., Peveler, R., Gabbay, J., & Kendrick, T. (2007). Qualitative study of depression management in primary care: GP and patient goals, and the value of listening. *The British journal of general practice: the journal of the Royal College of General Practitioners*, *57*(544), 872–879. doi: 10.3399/096016407782318026

Kan, K., Jörg, F., Buskens, E., Schoevers, R. A., & Alma, M. A. (2020). Patients' and clinicians' perspectives on relevant treatment outcomes in depression: qualitative study. *BJPsych open*, *6*(3). doi: 10.1192/bjo.2020.27

Keeley, R. D., West, D. R., Tutt, B., & Nutting, P. A. (2014). A qualitative comparison of primary care clinicians' and their patients' perspectives on achieving depression care: implications for improving outcomes. *BMC family practice, 15*, 13. doi: 10.1186/1471-2296-15-13

Leichsenring, F., & Schauenburg, H. (2014). Empirically Supported Methods of Short-Term Psychodynamic Therapy in Depression - Towards an Evidence-Based Unified Protocol. *Journal of Affective Disorders, 169*, 128–143. doi: 10.1016/j.jad.2014.08.007

Levitt, H. M. (2021). *Essentials of critical-constructivist grounded theory research.* American Psychological Association. doi: 10.1037/0000231-000

Luyten, P., & Blatt, S. J. (2012). Psychodynamic Treatment of Depression. *Psychiatric Clinics of North America*, *35*(1), 111–129. doi: 10.1016/j.psc.2012.01.001

Manning, C., & Marr, J. (2003). 'Real-life burden of depression' surveys—GP and patient perspectives on treatment and management of recurrent depression. *Current medical research and opinion*, *19*(6), 526–531. doi: 10.1185/030079903125002117

Mergenthaler, E., & Gril, S (1996). Descripción de las reglas para la transcripción de sesiones de psicoterapia. *Revista Argentina de Clínica Psicológica, 5*(2),163-176.

Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. J., & Sotsky, S. M. (2002). Treatment expectancies, patient alliance and outcome: Further analyses from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 70*(4), 1051–1055. doi: 10.1037/0022-006X.70.4.1051

Ministry of Health of the Government of Chile. (2017). *Guía Clínica: Para el tratamiento de la Depresión en personas mayores de 15 años: Actualización en Psicoterapia*. [Clinical Guide: For the treatment of Depression in people over

15 years of age: Updating in Psychotherapy]. *Ministry of Health, Government of Chile*. Available from: https://diprece.minsal.cl/wrdprss_minsal/wpcontent/uploads/2017/07/GPC_depresion_psicoterapia.pdf

Ministry of Health of the Government of Chile (2013). Guía clínica AUGE depresión en personas de 15 años y más (Series guías clínicas MINSAL) [AUGE Clinical Guide: Depression in People Aged 15 and Older (MINSAL Clinical Guidelines Series)]. *Ministry of Health, Government of Chile*. Available from: http://www.minsal.cl/portal/url/item/7222754637c08646e04001011f014e64.pdf

Mulder, R., Murray, G., & Rucklidge, J. (2017). Common versus specific factors in psychotherapy: opening the black box. *The Lancet Psychiatry*, *4*(12), 953-962. doi: 10.1016/S2215-0366(17)30100-1

OPD Taskforce (2008). *Operationalized Psychodynamic DiagnosticsOPD-2: manual of diagnosis and treatment planning*. Cambridge, MA: Hogrefe.

Ormel, J., Spinhoven, P., De Vries, Y., Cramer, A., Siegle, G., Bockting, C. & Hollon, S. (2019). The antidepressant standoff: why it continues and how to resolve it. *Psychological Medicine*, 1–10. doi: 10.1017/S0033291719003295

Owusu-Frimpong, N., Nwankwo, S., & Dason, B. (2010). Measuring service quality and patient satisfaction with access to public and private healthcare delivery. *International Journal of Public Sector Management*, *23*(3), 203-220. doi: 10.1108/09513551011032455

Prins, M. A., Verhaak, P. F. M., van der Meer, K. Penninx, B. W. J. H., & Bensing, J. M. (2009). Primary care patients with anxiety and depression: Need for care from the patient's perspective. *Journal of Affective Disorders*, *119*, 163-171. doi: 10.1016/j.jad.2009.03.019

Rizvi, S. L., Reynolds, S. K., Comtois, K. A., & Linehan, M. M. (2000, November). *Therapeutic alliance in the treatment of borderline personality disorder* [Paper presentation]. Association for Advancement of Behavior Therapy, New Orleans, LA.

Seewald, A., & Rief, W. (2023). How to Change Negative Outcome Expectations in Psychotherapy? The Role of the Therapist's Warmth and Competence. *Clinical Psychological Science*, *11*(1), 149–163. https://doi.org/10.1177/21677026221094331

Sotsky, S. M., Glass, D. R., Shea, M. T., Pilkonis, P. A., Collins, J. F., Elkin, I., Moyer, J. (1991). Patient predictors of response to psychotherapy and pharmacotherapy: Findings in the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry*, *148*, 997–1008. doi: 10.1176/ajp.148.8.997

Strauss, A. & Corbin, J. (2002). *Bases de la Investigación cualitativa. Técnicas y procedimientos para desarrollar la teoría fundamentad*a [Basis of qualitative research. Techniques and procedures to develop the grounded theory]. Editorial Universidad de Antioquía.

Swift, J. K., & Derthick, A. O. (2013). Increasing hope by addressing clients' outcome expectations. Psychotherapy, *50*(3), 284–287. doi: 10.1037/a0031941

Toro-Devia, O., & Leyton, G. (2023). COVID-19 pandemic and mental healthcare: Impact on health insurance with guaranteed universal access in Chile. *Frontiers in public health, 10*, 1005033. doi: 10.3389/fpubh.2022.1005033

Van Grieken, R. A., Beune, E. J., Kirkenier, A. C., Koeter, M. W., van Zwieten, M. C., & Schene, A. H. (2014). Patients' perspectives on how treatment can impede their recovery from depression. *Journal of affective disorders*, *167*, 153–159. doi: 10.1016/j.jad.2014.05.065

Van Schaik, D. J., Klijn, A. F., Van Hout, H. P., Van Marwijk, H. W., Beekman, A. T., De Haan, M., & Van Dyck, R. (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General hospital psychiatry*, *26*(3), 184-189. doi: 10.1016/j.genhosppsych.2003.12.001

Vîslă, A., Constantino, M., Newkirk, K., Ogrodniczuk, J. & Söchting, I. (2018) The relation between outcome expectation, therapeutic alliance, and outcome among depressed patients in group cognitive-behavioral therapy, *Psychotherapy Research*, *28*,3, 446-456. doi: 10.1080/10503307.2016.1218089

Wampold, B. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–777. doi: 10.1002/wps.20238

Weitkamp, K., Klein, E., Hofmann, H., Wiegand-Grefe, S., & Midgley, N. (2017). Therapy expectations of adolescents with depression entering psychodynamic psychotherapy: A qualitative study. *Journal of Infant, Child & Adolescent Psychotherapy, 16*(1), 93–105. doi: 10.1080/15289168.2016.1268883

Westra, H. A., Aviram, A., Barnes, M. & Angus, L. (2010). Therapy was not what I expected: A preliminary qualitative analysis of concordance between client expectations and experience of cognitive-behavioural therapy. *Psychotherapy Research, 20*(4), 436-446. doi: 10.1080/10503301003657395

Westra, H. A., Constantino, M. J., & Aviram, A. (2011). The impact of alliance ruptures on client outcome expectations in cognitive behavioral therapy. *Psychotherapy Research, 21*(4), 472–481. doi: 10.1080/10503307.2011.581708

Weinberger, J., & Eig, A. (1999). Expectancies: The ignored common factor in psychotherapy. In I. Kirsch (Ed.), *How expectancies shape experience* (pp. 357–382). American Psychological Association.