

Beliefs about psychotherapy among adults in La Araucanía, Chile Creencias sobre psicoterapia en adultos de La Araucanía, Chile

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Cultural factors relevant to psychotherapy, although highly relevant, have been poorly studied in the local context, with little clarity regarding the socially shared meanings about this kind of treatment. The aim of this study was to identify beliefs about psychotherapy among adults from La Araucanía region, Chile. Through a bottom up cultural research approach, 32 semi-structured interviews were conducted and examined using thematic analysis. Participants held mostly positive beliefs about psychotherapy itself and its results. However, understandings that could hinder adherence to psychotherapy were identified, as well as negative emotions associated with attending it. Additionally, participants displayed negative beliefs about the psychotherapy delivered in the public health system. These results provide a characterization of beliefs about psychotherapy among adults, and could serve as an input to understand psychotherapy adherence in this particular context.

Keywords: psychotherapy adherence, psychotherapy, beliefs about psychotherapy, cultural beliefs.

Los factores culturales asociados a la psicoterapia, pese a ser muy relevantes, han sido escasamente estudiados en el contexto local, existiendo poca claridad respecto de los significados que socialmente se comparten sobre este tipo de tratamiento. El objetivo de este estudio fue identificar las creencias sobre la psicoterapia entre adultos de la región de La Araucanía, Chile. A través de un enfoque de investigación cultural bottom up, se realizaron 32 entrevistas semi-estructuradas y fueron examinadas usando análisis temático. Los participantes sostenían mayoritariamente creencias positivas sobre la psicoterapia y sus resultados. Sin embargo, se evidenciaron entendimientos que podrían obstaculizar la adherencia a psicoterapia, así como emociones negativas evocadas por este tratamiento. Adicionalmente, los participantes mostraron creencias negativas sobre la psicoterapia realizada en el sistema público de salud. Estos resultados proveen una caracterización de las creencias sobre la psicoterapia que sostienen personas adultas y podrían servir de insumo para entender la adherencia a psicoterapia en este contexto particular.

Palabras clave: adherencia a psicoterapia, psicoterapia, creencias sobre psicoterapia, creencias culturales.

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Introduction

Mental health is critical to the well-being of individuals, societies and nations, and therefore, preventing and treating mental health problems is an increasingly important public health challenge (World Health Organization [WHO], 2013). While the former of these actions, prevention, represents an ideal, the default position is the latter, and considerable proportions of health resources of most developed countries are allocated to the provision of mental health treatment services. With the development of new psychotropic medications in the 1950s and the subsequent de-institutional movement that began in the 1960s, governments of developed nations have aimed to provide these services through outpatient community mental health centers, except in cases of severe and debilitating illness.

However, mental health treatments, and particularly psychotherapy, have not enjoyed a good reputation. Since Eysenck's verdict where effectiveness of psychotherapy was questioned (Eysenck, 1952), to negative beliefs about psychotherapy that are still glimpsed in people nowadays. In fact, research has demonstrated that beliefs regarding mental health treatments appear to play an important role in treatment-seeking and adherence. For example, Vogel, Wester, Wei, and Boyesen (2005) found an association between beliefs about effectiveness (or ineffectiveness) of psychotherapy and attitudes towards seeking psychotherapeutic help. Several other investigations (Ojeda & Bergstresser, 2008) have shown that negative beliefs about psychotherapy, such as considering it to be ineffective are associated with the premature termination of engagement in treatment (dropout). In contrast, Borkovec, Newman, Pincus, and Lytle (2002) have reported that belief in the credibility in psychotherapy is positively associated with treatment completion and clinically significant change post-treatment and at 6 and 12-month follow-up.

In the international context, frequent beliefs have been defined: the fear of asking for help, the questioning about the efficacy of psychotherapy, the belief that the symptoms will remit without treatment, and that the problems will be solved with the support of family and friends (Chartier-Otis, Perreault, & Belanger, 2010; Lorian & Grisham, 2011). In Chile, although socially shared

beliefs about psychotherapy have not been addressed, there is evidence regarding the reasons for not following mental health treatments in general (Vicente, Kohn, Saldivia, Rioseco, & Torres, 2005), which seem to be aligned with those mentioned above: "The problems will be solved spontaneously", "I can solve my problems by my own", "Mental treatments are expensive", "Fear of diagnosis", "Lack of time", "Concern about what others might think", among others.

The scarce information available in Chile, along with studies showing one of the highest levels of depression (17%) in Latin America (Ministerio de Salud [Minsal], 2013), the lowest budgets to invest in mental health (Minsal, 2017), and a lack of a well-developed mental health policy, justify the interest in knowing people's beliefs about one of the most used mental health treatments at the public primary healthcare system (Scharager Goldenberg & Molina Aguayo, 2007). Specifically, placing the study in the region of La Araucanía is relevant, because it presents high rates of untreated mental health problems, and one of the highest rates of poverty of the country (Ministerio de Desarrollo Social, 2018), the latter representing an important structural and social determinant of health.

Considering the above, the aim of the current study was to identify beliefs about psychotherapy among adult people in La Araucanía, Chile. The fulfilment of this aim would allow us to evaluate if local beliefs present specific elements (emic) to this cultural group and/or similar meanings to those internationally evidenced (etic).

Method

The study was conducted in the region of La Araucanía in southern Chile. As mentioned above, this region has been identified as the poorest in the country, with a poverty rate of 17.2% (Ministerio de Desarrollo Social, 2018), 8.6 percentage points above average. In line with this, the majority (90%) of the population is dependent on the public health system (about 857,000 people) (Ministerio de Desarrollo Social, 2013). This region was chosen for this research based on preliminary quantitative analysis of a national survey of health (Minsal, 2011), which indicated the highest levels of prevalence of depressive disorders in the country (27.3%).

This study is part of a research where mixed methods were used, involving from observations to the development of instruments (e.g., Salinas-Oñate, Ortiz, Baeza-Rivera, & Betancourt, 2017), and testing of hypotheses. The study illustrates data collection from a qualitative perspective, in which aspects of culture specifically relevant to psychotherapy were identified directly from the individuals, rather than based on stereotypical views. For this purpose, we use a bottom up cultural research approach based on methods for the study of subjective culture (Triandis, 1972) and Betancourt's research approach for the study of culture (Betancourt, Flynn, Riggs, & Garberoglio, 2010).

We undertook this research from a broadly phenomenological perspective in order to come to identify socially shared beliefs about psychotherapy among adults who have different demographic characteristics, recounting their experiences in relation with psychotherapy in the contexts in which they live, and the meanings of these experiences, and beliefs associated with them. Congruent with Monti and Tingen (1999), the ontological and epistemological assumptions underlying are that reality is complex and context dependent. Our approach valued multiple ways of knowing and allowed us to uncover the knowledge embedded in the experience of adult people in La Araucanía, in order to answer the following question that guided our study: Which are the beliefs about psychotherapy that are socially shared by adults in La Araucanía?

Participants

Through an intentional multi-stage sampling, 32 participants were recruited and interviewed. The recruitment process aimed to stratify the sample by the following criteria: (a) health system

used (public and private) which accounts for variability in socioeconomic status, and (b) age (under 30 and over 30 years old) to account for findings that people 30 years or less are more likely to dropout from psychotherapy (Muñoz Marrón, 2005). These dimensions generated a matrix of four cells, which —after several stages of sampling— included each eight participants on average (more details in table 1). The number in each cell varied depending on data saturation and the availability of the sample. It was considered an exclusion criterion any intellectual disability that would hinder participants from answering the interview properly (details on sample composition in table 2).

Interview

Data were collected through semi-structured individual interviews which were based on the protocol implemented by Betancourt et al. (2010) to study culture in health, and on the methodology proposed by Triandis (1972) for the study of subjective culture. The interviews explored the beliefs of participants about psychotherapy, expectations and emotions that psychotherapy generates (e.g., “What it is the first thing that comes to mind when you hear the word psychotherapy?”, “Why do you think people stay in psychotherapy and why do they dropout?”). They also explored whether such beliefs matched those of participants' family or close friends. Moreover, respondents were asked if they or significant people in their life (e.g., family members or friends) had had direct experience with psychotherapy, and if this had changed their beliefs about this process. Additionally, participant demographic data such as age, gender, ethnicity, educational level, and occupation were recorded.

Table 1
Sampling matrix

		Health system		Total
		Public	Private	
Age	30 years or less	6	5	11
	Over 30 years	11	10	21
	Total	17	15	32

Note. Average age = 34.1; standard deviation = 10.4.

Table 2
Composition of the sample

	Percentage
Sex	
Women	59.3
Men	40.7
Ethnicity	
Non mapuche	53.1
Mapuche	46.9
Health system	
Public	53.1
Private	46.9
Educational level	
Incomplete primary	3.1
Incomplete high school	6.2
Complete high school	21.9
Incomplete technical studies	15.6
Complete technical studies	18.8
Undergraduates	18.8
Postgraduate	15.6
Socioeconomic status	
Low	6.3
Middle low	22.0
Middle	28.0
Middle high	25.0
High	18.8
Very high	0.0
Experiences in psychotherapy	
Positive	56.3
Negative	9.4
Neutral	6.3
Non existent	28.0

Procedure

After obtaining the approval of the Scientific Ethics Committee of Universidad de La Frontera, participants were recruited from the general population in different contexts (neighborhood associations, educational institutions, etc.) and after reading a plain language description of the study signed an informed consent form (which explained the voluntary and confidential nature of their participation), indicating their willingness to engage with the study. Interviews were conducted by two researchers (investigator-in-charge and a co-investigator) in the participants' homes, and lasted approximately 40 minutes. Each interview was digitally recorded and later transcribed by a properly trained undergraduate assistant, and the transcription was checked with participants to assure the credibility of the data (Cádiz Henríquez, 2004). For the latter process, participants were asked to review the transcribed inter-

view, and then approve it or suggest any modifications. The confidentiality of the data was protected by coding participants' names (folio number) and using secured storage.

An iterative procedure of participant selection, interview, and data analysis was used, and recruitment ceased when no new themes emerged, and when the investigators determined that the themes were fully tested and refined within a diverse sample. After completing 32 interviews theoretical saturation was reached.

Data analyses

Thematic analysis, which is an atheoretical approach used to identify and analyze patterns within the qualitative data sets and is commonly used in studies of psychotherapy (May, Strauss, Coyle, & Hayward, 2014) was used to explore the data. It involves an iterative process by which data are encoded and then grouped into general themes that

are interpreted by their meaning. For this purpose, the software Atlas.ti was used.

A semantic approach was used to analyze the surface meaning of all interviews, after a process of familiarizing with the data (reading and rereading the transcribed interviews). Two investigators identified codes, which were then triangulated through the mechanism of coders' agreement (Miles & Huberman, 1994). The next step was to identify clusters of information, which grouped codes with related content.

Our method involved empathic contact with participants, and engagement of the researchers in all stages of the research process. Given that such immersion could "blind" researchers to nuances of meaning, we independently analyzed the data and reach consensus about the outcomes, to avoid potential biases in the process and to meet the criteria of rigor of testability (Guba, 1989) and evaluate the adequacy, quality and consistency of the analysis of the interviews. For this purpose, an external researcher was employed, who oriented the whole process.

Results

Three main themes in relation to participants' beliefs about psychotherapy were identified: beliefs about the treatment itself, beliefs about why people initiate or drop out this kind of treatment, and beliefs about emotions that emerge just thinking about the possibility of engaging in a psychotherapy process.

Beliefs about psychotherapy

As it shown in figure 1, the first theme related to beliefs about psychotherapy is a tendency of making reference to psychotherapy mainly from its perceived effects or outcomes. In the general level, psychotherapy is described as a treatment that works well. In relation to personal positive effects, promotion of self-knowledge was most commonly noted. This kind of belief was associated with previous good experiences in psychotherapy. These were followed by a great number of references to neutral effects or effects that can not necessarily be classified as positive or negative.

I did not know how it works (psychotherapy), how they know what your problem is, just listening at what you're telling. When I lived the

experience was poignant, before I have gone through a treatment with a psychologist, I thought an entirely different thing to having passed, it provoked a break in me... and also in my opinion regarding the profession (#29, male, < 30 years old, public health system, previous experience of psychotherapy).

On the other hand, negative effects of psychotherapy were also noted, the most frequent being the prescription of medication. The second major subcategory was related with beliefs about the process of psychotherapy, which fell into three categories. The most common incorporated negative elements of psychotherapy and emphasized the relative infrequency of psychotherapy sessions in the public healthcare system. The second category included various criticisms that participants made about the process of psychotherapy, the most popular being that it should give more tools to patients and be a more specific process. The last category focused on the positive elements of the process of psychotherapy, the most quoted being the value of having an outside observer that gives greater objectivity to the presenting problem.

Sometimes one gets engulfed by a problem, and can see no way out... Then they start talking to you.... I do not know... different topics and then tell you "why did you not apply this thing?", and of course, those are things that one could do, but you need the perspective of an outsider, because you will not see it by yourself (#30, male, < 30 years old, private health system, no history of psychotherapy).

The third category related to the concept of psychotherapy or what people mean by psychotherapy, both in its definition and specific characteristics attributed to the process. In general, psychotherapy tended to be defined as a conversation, and with regard to the specifics features of this treatment, the most quoted was that it is a long treatment.

It is all about talking, then they ask questions... and a lot of things come up... things that you didn't think you have inside (#24, female, < 30 years old, public health system, previous experience of psychotherapy).

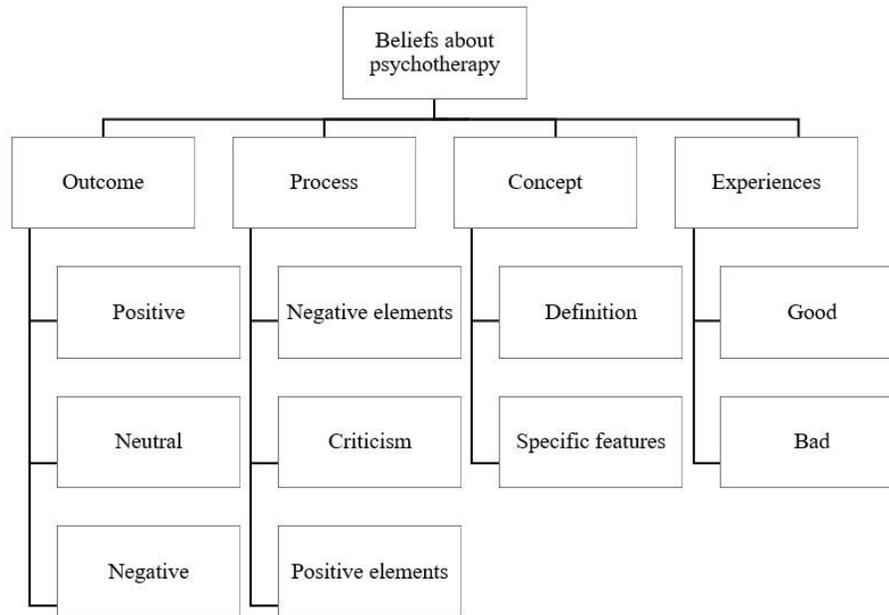


Figure 1. Beliefs about psychotherapy. Principal findings and clusters of information.

Beliefs about initiation and psychotherapy termination

The largest proportion of responses in this category focused on why people attend psychotherapy, with personal benefits being the most important cluster (figure 2). Within these the psychological benefits, feeling better or learning how to solve conflicts were the most popular.

It helps you; you feel better about yourself, it's for you, a psychological therapy is for you to be good about yourself and you feel complete. You learn that you are a unique person, and you have to accept yourself as you are (#07, male, > 30 years old, public health system, no history of psychotherapy).

The instrumental benefits were highlighted as motivation for attending therapy, even when it is not directly related with getting over the problem that led to initial engagement in psychotherapy. Accessing medication was also seen as an important benefit. Having a diagnosis was the next most common factor associated with the decision to attend psychotherapy, the most widely recognized being depression. A similar theme suggested that to attending psychotherapy certain preconditions should be met, the most quoted being recog-

nizing that there is a problem.

I think it's about the self-perception, when one realizes about it ... I think that's the main thing that needs to happen to welcome that kind of treatment, to realize that something is happening (#25, male, > 30 years old, public health system, previous experience of psychotherapy).

A more negative connotation emphasized "having a bad time". Of the remaining reasons why people attend psychotherapy, the most frequently quoted was "to be motivated" to attend, as a personal feature.

Of the reasons why people choose not to attend psychotherapy, an important number of quotes were related to psychological factors, mainly negative emotions that are experienced. Fear was the most mentioned, mainly in association with the stigma related with being a mental health patient (e.g., "crazy"). In addition, they mention reluctance as a reason not to attend, such as not recognizing a problem or being autonomous.

If I was the person who will go to a psychologist...I would fear that other people know that I'm seeing a psychologist because they'll think I'm crazy, they will start to pressure me, asking

me what's up, what's wrong (#07, male, > 30 years old, public health system, no history of psychotherapy).

Participants also emphasized logistical factors that lead to not attending psychotherapy. The most frequently mentioned was lack of money. On the other hand, regarding the decision to abandon psychotherapy, personal reasons were most common. The most often cited was "feeling well".

Furthermore, with respect to psychotherapy factors that motivate dropping out, the most common concerned was the slowness of the process.

Because they feel they have no progress, because they believe it's instantaneous, like taking pills, and tomorrow I will be fine. That's not the way it is, it is a process... So, thinking it's going to take three days... it is not like that, if it's something you've dragged for many years (#17, female, < 30 years old, private health system, no history of psychotherapy).

Finally, regarding the reasons to continue psychotherapeutic process once started, the positive factors mainly related were "feeling good", while negative factors included "fear of relapse".

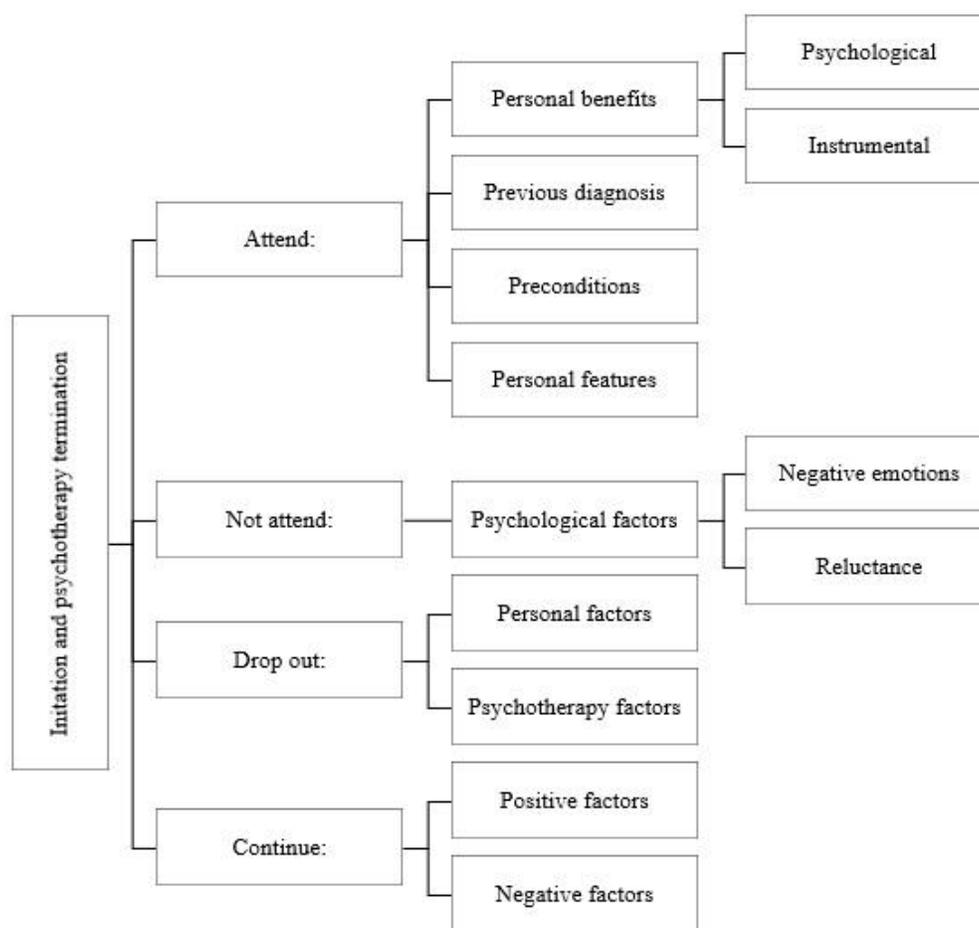


Figure 2. Beliefs about initiation and psychotherapy termination. Principal findings and clusters of information.

Emotions associated with attending psychotherapy

As shown in figure 3, interviewees reported mostly negative emotions in relation to attending

psychotherapy, highlighting "fear" as the most important. This was accompanied by many reasons why people feel afraid of, for non-specific reasons, fear of the unknown and even fear to the

lack of confidentiality of the process. Performance anxiety was a prevalent experience. Other less reported emotions were noted, as sadness, frustration, shame and anger.

Positive emotions highlighted “relief” as associated to psychotherapy

A relief because one gets to cry, to tell the problems and all that, but I think it's a relief because sometimes I requested consecutive hours to go and tell her more things and everything (#16, female, > 30 years old, public

health system, previous experience of psychotherapy).

The analyses also identified passive ego states that are experienced as pleasant or unpleasant (Schneider, 1980) (figure 4). These differ from emotions because they are less intense. Most were neutral in character, and were associated with the expectancy of psychotherapy, and therefore, did not signify a pleasant or unpleasant state, but an attitude of alert anticipation of what might happen.

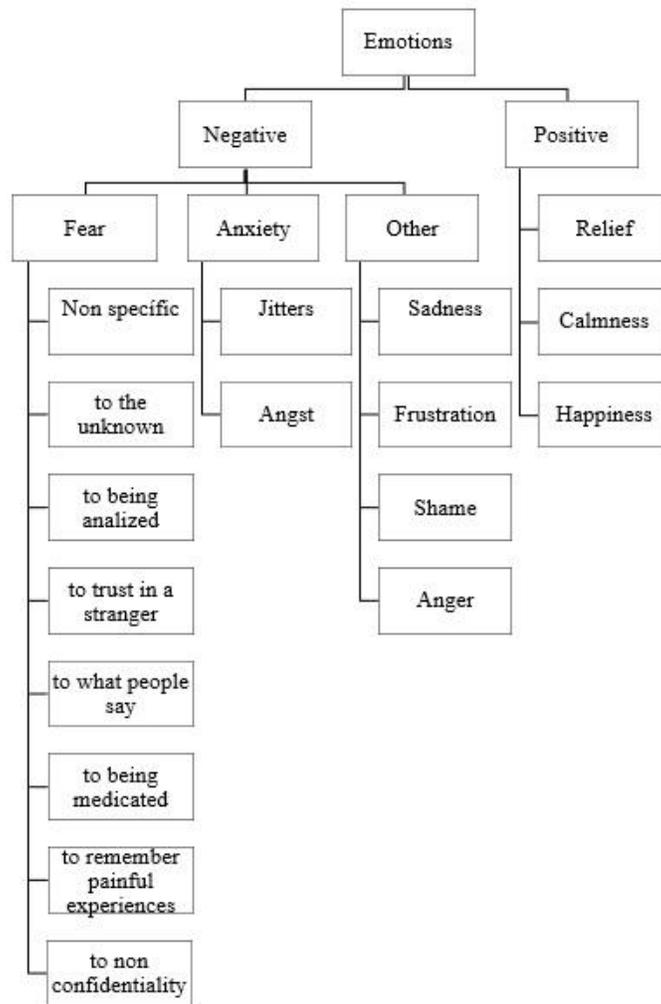


Figure 3. Emotions associated with attending psychotherapy. Principal findings and clusters of information.

Expectancy of how it could be, she (the therapist) could be tricky or she could be friendly (#30, male, < 30 years old, private health system, no history of psychotherapy).

These emotions are followed by positive feelings, among “a sense of freedom” was highlighted. Finally, in relation to negative feelings “discomfort” was the most cited.

It can also be uncomfortable, because you’re going to tell your problems, your mess... your stuff to a person who has no idea about you, that you have never seen before... maybe that’s why therapies are often lengthy... because first you have to gain confidence with the person who you’re telling your stuff to (#07, male, > 30 years old, public health system, no history of psychotherapy).

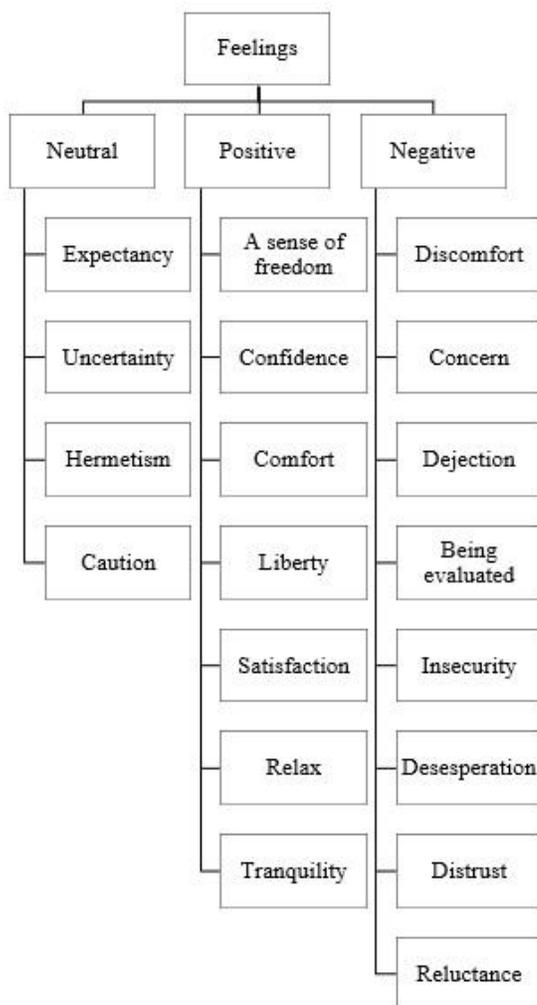


Figure 4. Feelings associated with attending psychotherapy. Principal findings and clusters of information.

Discussion

Since several decades ago, there has been a growing interest in identifying the impact that beliefs have on health outcomes and adherence to treatments (Betancourt, 2015; Betancourt et al.,

2010). In relation to psychotherapy, some studies have investigated these beliefs in developed countries where psychotherapy has a long history (e.g. Edlund et al., 2002). This contrasts with the Chilean context, where psychologists were the latest professional group to join the primary care sys-

tem, only two decades ago (Scharager Goldenberg & Molina Aguayo, 2007) and where there is scarce research about socially shared beliefs about psychotherapy. While international studies suggest that structural determinants, cultural variables, and psychological factors work together to explain engagement with and adherence to mental health treatment, one of the challenges has been to identify the variables relevant to the population in which psychotherapy will be delivered.

This research identified beliefs about psychotherapy among adults in the region of La Araucanía in southern Chile. The most striking aspect of the findings was the high frequency of positive views about psychotherapy, including beliefs about psychotherapy itself, and the positive results for people who use it, among which are: psychotherapy helps the patients to discover the solutions to their problems, seeing things from another point of view, or to overcome difficult moments in their lives.

The above appears along with negative beliefs that are similar to what international literature has described as the most important beliefs about psychotherapy (e.g., Vogel & Wester, 2003). In fact, the few studies that have identified positive beliefs about mental health treatment have reported them in relation to antidepressant drugs, or compared attitudes, whether favorable or unfavorable (Jorm et al., 2000) or patients' preferences for drug therapy or psychotherapy (Lang, 2005), without delving into whether these attitudes come from socially shared beliefs about those treatments.

The presence of these positive beliefs despite the unfavorable context in terms of investment in mental health is surprising. This finding is associated with the impact of previous positive experiences with psychotherapy, that allows patients to understand the complexity of the process and change previous negative thoughts and expectations about the treatment.

Local findings open new questions about how positive beliefs could be reflecting idiosyncratic features or cross-cultural differences about specific ways to understand a psychotherapy process, that could be addressed in future studies. In addition, it opens new possibilities to study not only the impact on psychotherapy-related behaviors and outcomes of negative beliefs, but also how positive beliefs also influence such outcomes.

Besides, participants also reported that the out-

comes of psychotherapy depend predominantly on the patient's disposition. This is consistent with psychotherapy literature on generic indicators of change in psychotherapy (Echávarri et al., 2009). In this literature, the first level (initial consolidation of therapeutic alliance structure) relies mainly on the client's acceptance that they have a problem or the acceptance of the therapist as a competent professional (Fernández, Pérez, Gloger, & Krause, 2015).

Despite expressing positive beliefs, participants also commented on the difficulties of psychotherapy in the public system, where the problem of infrequency of sessions was emphasized. They suggested that the long time that passes between sessions, due to the high demand, is likely related to negative effects, which is something that must be taken into account in formulating policy about mental health service delivery. Participants' observations could be related to the fact that even though the primary care system is mostly oriented to promotion of preventive factors for mental health (Minsal, 2000), because of the high rates of mental health disorders in Chile the focus has been mainly on treatment (Scharager Goldenberg & Molina Aguayo, 2007). This has consequences for the quality of care, in that appointments with psychologists are shorter and less frequent than would be optimal.

Participants also identified a need for a more concrete process that delivers more specific tools to patients. This appeared to be associated with an understanding that psychotherapy is a long process that involves a lot of talk, but sometimes delivers no results. This challenges the discipline to provide both patients and the public more generally with evidence about the effectiveness of this type of treatment.

In relation to the question regarding why people commence psychotherapy, participants suggested two reasons. On the one hand, personal benefits, closely linked to the expectation of being cured, and the intrinsic motivation to feel better as a consequence of psychotherapy, were important. This kind of expectation is often referred to as "process expectations" (Glass, Arnkoff, & Shapiro, 2001; Noble, Douglas, & Newman, 2001). On the other hand, instrumental benefits (e.g., obtaining medication) were seen to be an alternative motivating factor. These benefits are less related to the psychologist's role, which is

also interesting because the literature shows that the more congruence between the patient's expectations about psychotherapy and reality, the more likely they are to adhere to treatment (Reis & Brown, 2006; Swift & Callahan, 2008). In fact, Garfield (1994) points out that those who drop out of psychotherapy have less accurate expectations about the therapist's role, and usually expect to play a passive role in the process.

Consistent with the international literature (Simon, Imel, Ludman, & Steinfeld, 2012), feeling better (and therefore no longer in need of therapy) was seen to be a reason for dropping out of psychotherapy. Therefore, psychotherapy dropout should not be seen just as a negative indicator (Wierzbicki & Pekarik, 1993). However, dropping out of treatment may mean that patients do not receive all the components of a given treatment (Weisz, Weiss, & Langmeyer, 1987). Further, their difficulties may compound over time (Armbruster & Kazdin, 1994). Indeed, little is known about whether rapid and self-assessed improvement is maintained over time.

Other factors reported to be associated with dropout related to psychotherapy itself—for example, the slowness of the process and the expectation that psychotherapy would be a more concrete process and show results faster. In essence, these factors suggest that the kind of expectations mentioned above have not been met. Nevertheless, this tendency could be more pronounced in the public health system where the sessions are more spaced over time than in the private sector.

Several negative emotions were associated with psychotherapy. These include fear related to the “unknown”, of being “analyzed”, telling things to a stranger, of what “people will say”, of remembering painful events, and of being medicated. This is consistent with current international findings (Savage et al., 2016) that reasons for not seeking professional help include fear of being stigmatized for having a mental disorder and help-seeking, and negative expectations of professional help and believing that informal strategies will be sufficient. Thus, the current situation seems not to be so different from classical descriptions about psychotherapy as “a potentially difficult, embarrassing, and overall risky enterprise... [that can] induce fear and avoidance in some individuals” (Kushner & Sher 1989, p. 256). In addition, the evidence suggests that even if psychotherapy is

framed positively, it is still perceived as a threat, because of the stigma and generation of negative self-assessments that challenge one's own competence, suitability, stability and consistency (Vogel, Hansen, Stiles, & Götestam, 2006).

Nevertheless, it is worth noting how the mere thought of going to psychotherapy triggers a series of negative emotions that may negatively impact on attending a treatment that could be highly effective and recommended by another health professional. Some of those fears reflect inaccurate beliefs about the psychologist's role (fear of being medicated). This is highly relevant because negative emotions have shown strong associations with worst health outcomes (Flynn et al., 2015; Tucker, 2008).

This study has several advantages, such as identifying beliefs in a diverse sample, using an accurate methodology for the study of cultural aspects. However, it was not free of limitations, including that stratification of the sample considered two principal variables (health system and age). Future studies could incorporate other sources of cultural variation such as ethnicity and acculturation, in order to identify aspects that probably have not emerged in the present investigation. Additionally, these findings could serve as an input for the development of culturally relevant measures that would examine the distribution of these beliefs and attitudes in a larger sample from a quantitative perspective, and subsequently, assess the impact of these beliefs on some relevant health behaviors, such as psychotherapy help-seeking and adherence. Finally, it would be interesting to explore this type of beliefs in other areas of Chile, since there may be other sources of cultural variation (e.g., migratory status) that could be relevant to explore.

Overall, the study provides some preliminary indications of belief attitudes about engagement and adherence to psychotherapy in a context in which community and outpatient mental health services are relatively new.

References

- Armbruster, P. & Kazdin, A. E. (1994). Attrition in child psychotherapy. In *Advances in Clinical Child Psychology* (pp. 81-108). Boston, Massachusetts: Springer.
https://doi.org/10.1007/978-1-4757-9041-2_3
- Betancourt, H. (2015). Investigación sobre cultura y

- diversidad en psicología: una mirada desde el modelo integrador. *Psykhē*, 24(2), 1-4.
<https://doi.org/10.7764/psykhe.24.2.974>
- Betancourt, H., Flynn, P. M., Riggs, M., & Garberoglio, C. (2010). A cultural research approach to instrument development: The case of breast and cervical cancer screening among Latino and Anglo women. *Health Education Research*, 25(6), 991-1007.
<https://doi.org/10.1093/her/cyq052>
- Borkovec, T. D., Newman, M. G., Pincus, A. L., & Lytle, R. (2002). A component analysis of cognitive-behavioral therapy for generalized anxiety disorder and the role of interpersonal problems. *Journal of Consulting and Clinical Psychology*, 70(2), 288-298.
<https://doi.org/10.1037/0022-006X.70.2.288>
- Cádiz Henríquez, J. (2004). Rigurosidad científica y principios orientadores para el evaluador/investigador. *Ars Médica, Revista de Estudios Médicos Humanísticos*, 33(1), 120-128.
 Retrieved from <https://bit.ly/2WTqDfB>
- Chartier-Otis, M., Perreault, M., & Belanger, C. (2010). Determinants of barriers to treatment for anxiety disorders. *The Psychiatric Quarterly*, 81(2), 127-138.
<https://doi.org/10.1007/s11126-010-9123-5>
- Echavarrí, O., González, A., Krause, M., Tomicic, A., Pérez, C., Dagnino, P., ... Reyes, L. (2009). Cuatro terapias psicodinámicas breves exitosas estudiadas a través de los indicadores genéricos de cambio. *Revista Argentina de Clínica Psicológica*, 18(1), 5-19.
 Retrieved from <https://bit.ly/31gc3hx>
- Edlund, M. J., Wang, P. S., Berglund, P. A., Katz, S. J., Lin, E., & Kessler, R. C. (2002). Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. *American Journal of Psychiatry*, 159(5), 845-851.
<https://doi.org/10.1176/appi.ajp.159.5.845>
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16(5), 319-324.
<http://dx.doi.org/10.1037/h0063633>
- Fernández, O., Pérez, C., Gloger, S., & Krause, M. (2015). Importancia de los cambios iniciales en la psicoterapia con adolescentes. *Terapia Psicológica*, 33(3), 247-255.
 Retrieved from <https://bit.ly/2KB0BXU>
- Flynn, P. M., Betancourt, H., Garberoglio, C., Regts, G. J., Kinworthy, K. M., & Northington, D. J. (2015). Attributions and emotions regarding health care mistreatment impact continuity of care among Latino and Anglo American women. *Cultural Diversity and Ethnic Minority Psychology*, 21(4), 593-603.
<https://doi.org/10.1037/cdp0000019>
- Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 190-228). Oxford, United Kingdom: John Wiley & Sons.
- Glass, C. R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 455-461.
<https://doi.org/10.1037/0033-3204.38.4.455>
- Guba, E. G. (1989). Criterios de credibilidad en la investigación naturalista. In S. Gimeno Sacristán & A. Pérez Gómez (Eds.), *La enseñanza: su teoría y su práctica* (pp. 148-165). Madrid, España: Akal.
- Jorm, A. F., Medway, J., Christensen, H., Korten, A. E., Jacomb, P. A., & Rodgers, B. (2000). Public beliefs about the helpfulness of interventions for depression: Effects on actions taken when experiencing anxiety and depression symptoms. *Australian and New Zealand Journal of Psychiatry*, 34(4), 619-626.
<https://doi.org/10.1080/j.1440-1614.2000.00761.x>
 Retrieved from <https://bit.ly/2EXrhi6>
- Kushner, M. G. & Sher, K. J. (1989). Fear of psychological treatment and its relation to mental health service avoidance. *Professional Psychology: Research and Practice*, 20(4), 251-257.
<https://doi.org/10.1037/0735-7028.20.4.251>
- Lang, A. J. (2005). Mental health treatment preferences of primary care patients. *Journal of Behavioral Medicine*, 28(6), 581-586.
<https://doi.org/10.1007/s10865-005-9019-2>
- Lorian, C. N. & Grisham, J. R. (2011). Clinical implications of risk aversion: An online study of risk-avoidance and treatment utilization in pathological anxiety. *Journal of Anxiety Disorders*, 25(6), 840-848.
<https://doi.org/10.1016/j.janxdis.2011.04.008>
- May, K., Strauss, C., Coyle, A., & Hayward, M. (2014). Person-based cognitive therapy groups for distressing voices: A thematic analysis of participant experiences of the therapy. *Psychosis*, 6(1), 16-26.
<https://doi.org/10.1080/17522439.2012.708775>
- Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, California: Sage Publications.
- Ministerio de Desarrollo Social. (2013). *Resultados Regionales Encuesta Casen 2011: Región de La Araucanía*. Santiago, Chile.
 Retrieved from <https://bit.ly/2WkOVec>
- Ministerio de Desarrollo Social. (2018). *Síntesis de resultados. Situación de pobreza en Chile. Encuesta Casen 2017*.
 Retrieved from <https://bit.ly/2OXrmop>
- Ministerio de Salud. (2000). *Plan nacional de salud mental y psiquiatría. Documento técnico*. Santiago,

- Chile: Ministerio de Salud.
 Ministerio de Salud. (2011). *Encuesta nacional de salud Chile 2009-2010*. Retrieved from <https://bit.ly/2Kr46hD>
- Ministerio de Salud. (2013). *Guía clínica Auge. Depresión en personas de 15 años y más*. Santiago, Chile: Ministerio de Salud. Retrieved from <https://bit.ly/2Flc1xM>
- Ministerio de Salud. (2017). *Plan nacional de salud mental 2017-2025*. Santiago, Chile: Ministerio de Salud. Retrieved from <https://bit.ly/2Iu3mel>
- Monti, E. J. & Tingen, M. S. (1999). Multiple paradigms of nursing science. *Advances in Nursing Science, 21*(4), 64-80. Retrieved from <https://bit.ly/2nLCytc>
- Muñoz Marrón, E. (2005). *El abandono terapéutico en salud mental*. Madrid, España: Mapfre.
- Noble, L. M., Douglas, B. C., & Newman, S. P. (2001). What do patients expect of psychiatric services? A systematic and critical review of empirical studies. *Social Science & Medicine, 52*(7), 985-998. [https://doi.org/10.1016/S0277-9536\(00\)00210-0](https://doi.org/10.1016/S0277-9536(00)00210-0)
- Ojeda, V. D. & Bergstresser, S. M. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior, 49*(3), 317-334. <https://doi.org/10.1177/002214650804900306>
- Reis, B. F. & Brown, L. G. (2006). Preventing therapy dropout in the real world: The clinical utility of videotape preparation and client estimate of treatment duration. *Professional Psychology: Research and Practice, 37*(3), 311-316. <https://doi.org/10.1037/0735-7028.37.3.311>
- Salinas-Oñate, N., Ortiz, M. S., Baeza-Rivera, M. J., & Betancourt, H. (2017). Desarrollo de un instrumento culturalmente pertinente para medir creencias en psicoterapia. *Terapia Psicológica, 35*(1), 15-22. <http://doi.org/c6zq>
- Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. L. (2016). Exploring professional help-seeking for mental disorders. *Qualitative Health Research, 26*(12), 1662-1673. <https://doi.org/10.1177/1049732315591483>
- Scharager Goldenberg, J. & Molina Aguayo, M. L. (2007). El trabajo de los psicólogos en los centros de atención primaria del sistema público de salud en Chile. *Revista Panamericana de Salud Pública, 22*(3), 149-159. <https://doi.org/10.1590/S1020-49892007000800001>
- Schneider, K. (1980). *Las personalidades psicopáticas*. Madrid, España: Morata.
- Simon, G. E., Imel, Z. E., Ludman, E. J., & Steinfeld, B. J. (2012). Is dropout after a first psychotherapy visit always a bad outcome? *Psychiatric Services, 63*(7), 705-707. <https://doi.org/10.1176/appi.ps.201100309>
- Swift, J. K. & Callahan, J. L. (2008). A delay discounting measure of great expectations and the effectiveness of psychotherapy. *Professional Psychology: Research and Practice, 39*(6), 581-588. <https://doi.org/10.1037/0735-7028.39.6.581>
- Triandis, H. C. (1972). *The analysis of subjective culture*. New York, New York: Wiley-Interscience.
- Tucker, J. A. (2008). *Cultural beliefs about health professionals, attributions for mistreatment, and continuity of cancer-related care*. Loma Linda, California: Loma Linda University.
- Vicente, B., Kohn, R., Saldivia, S., Rioseco, P., & Torres, S. (2005). Patrones de uso de servicios entre adultos con problemas de salud mental, en Chile. *Revista Panamericana de Salud Pública, 18*(4/5), 263-70. Retrieved from <https://bit.ly/2XtLWp7>
- Vogel, D. L. & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*(3), 351-361. <https://doi.org/10.1037/0022-0167.50.3.351>
- Vogel, D. L., Wester, S. R., Wei, M., & Boysen, G. A. (2005). The role of outcome expectations and attitudes on decisions to seek professional help. *Journal of Counseling Psychology, 52*(4), 459-470. <https://doi.org/10.1037/0022-0167.52.4.459>
- Vogel, P. A., Hansen, B., Stiles, T. C., & Götestam, K. G. (2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry, 37*(3), 247-255. <https://doi.org/10.1016/j.jbtep.2005.12.001>
- Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1987). Giving up on child psychotherapy: Who drops out? *Journal of Consulting and Clinical Psychology, 55*(6), 916-918. <https://doi.org/10.1037/0022-006X.55.6.916>
- Wierzbicki, M. & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195. <https://doi.org/10.1037/0735-7028.24.2.190>
- World Health Organization. (2013). *Salud mental: un estado de bienestar*. Retrieved from <https://bit.ly/2wJNYBQ>
- World Health Organization. (2016). *La inversión en el tratamiento de la depresión y la ansiedad tiene un rendimiento del 400%*. Retrieved from <https://bit.ly/20Ekt1Q>

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