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EXPECTATIONS REGARDING PSYCHOTHERAPY AND THERAPEUTIC ALLIANCE IN WOMEN WITH DEPRESSION: A STUDY IN TWO DIFFERENT CULTURAL CONTEXTS.

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Dedication

This thesis is dedicated to my husband Nicolás, my daughters Julieta and Margarita, and my parents Antonio and Patricia.

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Abstract

The objective of the present study is to determine the relationship between psychotherapy expectations and early therapeutic alliance (first and third session) in women with depression in different cultural contexts (Chile and Germany), exploring the association between these variables and specific cultural variables such as dependent/interdependent self-construal, traditional/egalitarian sex role ideology, and the rigidity/laxness of social and familial norms. The sample consists of two groups of patients receiving psychotherapy, one in Chile and another in Germany. The first group is made up by 46 women diagnosed with depression, while the other consists of 30 female participants with the same diagnosis. The participants' age ranges between 20 and 50 years.

The Chilean participants were contacted at Psicomédica, an outpatient mental health center in Santiago. They were receiving treatment which followed different theoretical psychotherapeutic approaches, once a week. The German women were recruited at the General and Psychosomatic Medicine Clinic (Heidelberg University Hospital), where they received inpatient treatment with a psychodynamic approach in two weekly sessions.

The participants' level of depression was measured with the Beck Depression Inventory BDI-I (Beck, Ward, Mendelson, Mock & Erbaugh, J., 1961) both in Chile and Germany (Hautzinger, Bailer, Worall & Keller, 1994 [BDI-I]), before the first session.

Also, a clinical interview was implemented in Chile, the MINI International Neuropsychiatric Interview (Lecubrier, Sheehan, Weiller, Amorim, Bonora, Sheehan, Janavs & Dunbar, 1997), while in Germany the Patient Health Questionnaire of Depression PHQ-D (Spitzer, Kroenke & Williams 1999) was used.

Patient expectations were measured with the Patient Expectations Evaluation PATHEV (Schulte, 2005) in Chile and Germany, before beginning the psychotherapeutic process.

Cultural variables were measured with the same questionnaire battery in both countries: the Multidimensional Cultural Variables Questionnaire for Chile (Olhaberry, Crempien, Biedermann, Cruzat, Martínez, V., Martínez, F. & Krause, 2011 [CMVC]) and the

Battery of Multidimensional Cultural Variables (Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer, 2010 [HKFB]) for Germany.

The therapeutic alliance was measured with the Working Alliance Inventory, WAI (Santibañez, 2001), in Chile and WAI-SR (Wilmers, Munder, Leonhart, Herzog, Plassmann, Barth, & Linster, 2008) in Germany, after the first and third sessions.

Concerning the results of the comparison, significant differences between Chile and Germany were found in specific cultural variables (dependent and interdependent self-concept, social norms, sexual role ideology) and the therapeutic alliance as measured in sessions 1 and 3 (A1 and A3).

In Chile, a positive association was observed between expectations and the alliance of session 1 (A1) but not with that of session 3 (A3). In Germany, expectations displayed a positive association with the alliance of session one (A1) and that of session three (A3).

Regarding the relationship between cultural variables and the alliance, a positive association between independent self construal and A1 was found in Chile. In Germany, a positive association was observed between interdependent self-construal and A1; in addition, the egalitarian sex role ideology displayed a positive association with A1.

Based on the results analyzed in both countries, it can be concluded that no significant association is present in the relationship between expectations and cultural variables.

Likewise, no significant association was found in Chile and Germany between depression levels and expectations, nor was a link discovered between specific cultural variables and depression levels and the therapeutic alliance (A1 and A3).

Introduction

The present study analyzed the influence of culture in factors common to all therapies, such as expectations and the therapeutic alliance in women with depression living in two different cultural contexts: Chile and Germany. We chose to work on depression in women due to the high prevalence of this disorder both in Chile and Germany (Jacobi, Wittchen, Hölting, Höfler, Müller, Pfister & Lieb, 2004a; Ministry of Health (MINSAL), 2013; Vicente, Rioseco, Saldivia, Kohn & Torres, 2002). In addition, depression is a frequent mental disorder which affects over 350 million people in the world, is the main cause of disability globally, and greatly contributes to the world's morbidity burden (World Health Organization [WHO], 2012).

WHO (2003) points out that:

> "Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration" (http://www.who.int/topics/depression/en/).

Depression can become a serious health problem, especially when it is moderate or severe and is experienced over a long period. It can cause difficulties in a person's work, school, and family environments (WHO, 2012).

The present study focused on female patients with a depression diagnosis, given that a number of studies have found that women display a greater prevalence of this disorder than men, both in Chile and Germany, with such differences present in several cultures (Kessler, McGonagle, Swartz, Blazer & Nelson, 1993; Vicente, et al., 2002; Jacobi, et al, 2004).

This research included women aged 25-50, due to the fact that the impact of depression in women tends to increase during their fertile years, that is, between 15 and 44 years of age (WHO, 2008), and because depression is more often present in the working-age population (25 to 64 years) (MINSAL, 2013).

It has been pointed out that factors such as anxiety, stress, biological, social, and cultural aspects, and raising children can predispose women to depression in these stages of their lives (Brown, 1978; Weissman, 1987; Jadresic, 1990; Araya, Rojas, G., Fritsch, Gaete,

Rojas, M. & Peters, 2003; Sheeline, Wang, Gado & Kraemer, 2003; Araya, Rojas & Lewis, 2005).

Specific cultural variables were studied, such as self-concept (dependent/interdependent), sexual role ideology (egalitarian/traditional), and the rigidity or laxness of social norms, bearing in mind that the literature mentions that culture—a society's cultural beliefs and practices—has an impact on people's help seeking behavior and on the therapeutic process (Berry, Poortinga, Segall & Dasen, 2002; Krause, 2005).

The present study took into account two common factors in psychotherapy: the therapeutic alliance and patient expectations (Ingram, Hayes, & Scott, 2000; Reiter, 2010).

A number of authors have considered common factors to be ingredients or elements which have a positive or negative impact on the therapeutic process and its outcome (Grencavage & Norcross, 1990; Greenberg, Constantino, & Bruce, 2006; Lambert, 1992; Norcross & Lambert, 2011).

Patient expectations of psychotherapy were another variable. In general terms, they are viewed as cognitions about a probable future condition or event (Arknof, Glass & Shapiro, 2002). With respect to this construct, the literature shows that several types of expectations exist: for instance, of the therapist, of one's role, and of the treatment's outcome and effectiveness (Arknof, Glass & Shapiro, 2002).

Nevertheless, the present study focused on patient expectations of the treatment's outcome, which refer to a general trust in its effectiveness, expected recovery, and therapeutic change (Delsignore & Schnyder, 2007).

Regarding culture, evidence shows that it has a bearing on expectations (Berry, Poortinga, Segall & Dasen, 2002; Krause, 2005; Schulte, 2008).

In this regard, according to Frank (1991), specific cultural beliefs, as well as symbols about the therapist's curative powers, have an impact on patient perceptions and expectations before starting the psychotherapeutic process.

It must also be pointed out that there is a relationship between expectations and the quality of the therapeutic alliance (Castonguay, Constantino, & Holtforth Grosse, 2006;

Gaston, Marmar, Gallagher & Thompson, 1989; Hatcher & Barends, 1996; Horvath, Del Re, Flückiger, & Symonds, 2011; Meyer, Pilkonis, Krupnick, Egan, Simmens & Sotsky 2002). Likewise, a connection between depression and expectations has also been observed (Schulte, 2008; Sotsky, Glass, Shea, Pilkonis, Collins & Elkin, 1991).

In the present research, the therapeutic alliance variable was analyzed using the conceptualization advanced by Bordin (1976, 1979) of an entity made up by three related components which determine the quality of the working alliance: agreement on the treatment's goals and tasks and the development of the bond.

The study focused on the early therapeutic alliance, which is created and measured in the first phase of the treatment, that is, during the first and third sessions. In this respect, studies show that the therapeutic alliance established at the start of the treatment appears to be a better outcome predictor than alliance assessments conducted in the middle or final phases of the therapeutic process (Castonguay, Constantino, Holtforth & Grosse, 2006; Horvath 2005, 2011; Martin, Garske & Davis, 2000).

The present study was carried out in two different cultural contexts Chile and Germany with data obtained in the natural settings where the psychotherapies took place. It must be noted that the literature does not indicate the presence of transcultural studies conducted in these countries or others—which analyze the association between specific cultural variables and variables of the therapeutic process, such as the therapeutic alliance and psychotherapy expectations in women depression.

As a result, this study focused on the relationship between common factors in psychotherapy such as expectations and early alliance, and specific cultural variables in women with depression in two sociocultural contexts (Chile and Germany).

Cultural variables, as well patient expectations and the therapeutic alliance, were quantitatively evaluated using self-report instruments. Data analysis involved statistical procedures, conducted using SPSS 20.0, which included Student's t tests and bivariate logistic regressions.

The following pages present the theoretical and empirical background which supports this research, along with its general objectives, specific objectives, hypotheses, methodological aspects, and results, followed by a summary and discussion.

Theoretical and empirical background

Common factors to all psychotherapies which influence the therapeutic process

The following is a brief reference and overview of two common factors in psychotherapy which were considered in the present study: expectations and the therapeutic alliance.

The literature shows that common factors have an effect on the therapeutic process and its outcomes (Frances, Sweeney & Clarkin, 1985; Grencavage & Norcross, 1990).

Authors such as Ingram, Hayes & Scott (2000) regard common factors as resources for psychotherapeutic change and as elements shared by all forms of psychotherapy.

In this regard, Reiter (2010) mentions that common factors constitute the trans-theoretical understanding of the basic processes in any psychotherapeutic approach which can lead to positive results in therapy. Likewise, Goldfried (1982), Luborsky, Singer & Luborsky (1975), and Smith, Glass & Miller (1980) pointed out that common factors are active ingredients in psychotherapy, which, in essence, are equivalent in all psychotherapeutic approaches.

Other authors regard common factors differently. Frank (1982), for example, based on social psychology, has posed that the common element in all therapies is the therapist's persuasion of the patient. In his view, persuasion is an interpersonal influence process aimed at producing a change in attitude. For this author, the common elements which influence the psychotherapy are those related with the interpersonal relationship between patient and therapist, which is present in all types of therapies. Another influential element for Frank is the place where the therapy is conducted. Carrying it out in a special place, such as in a clinical context, in a professional's office, contributes to strengthening the patient's expectations of being cured; in addition, such places allow the patient to take the risk of engaging in positive behaviors.

Grencavage & Norcross (1990) has posited that common factors can be classed into five categories: client characteristics, therapist qualities, change process, treatment structure, and therapeutic relationship. Client characteristics include socio-demographic variables, socioeconomic status, gender, motivation, hope, and expectations regarding the psychotherapy.

For his part, Wampold (2012) has mentioned that common factors are those which are uniquely human. That is, common factors in psychotherapy involve human characteristics, which include giving meaning to the world, social and cultural influence, expectations, and one's connection with the other.

Also, both the beliefs and expectations of patients before the start of the psychotherapy, their positive or negative personal attitude towards the treatment, therapist variables such as attitude, acceptance, understanding of the patient, among others, are examples of elements that influence the therapeutic process, especially in terms of its outcome and the patient's recovery.

Several authors have advanced the existence of common factors in psychotherapy which have a bearing on patient recovery (Lambert, 1992, 2002; Norcross & Lambert, 2011). For his part, in a meta-analysis of therapeutic outcomes, Lambert (1992a, 2002) found that client change derives from four main resources. The first is extra-therapeutic change, which includes the client's personal traits as well as the environmental factors which lead to change. This represents 40% of the variance of the change (Lambert, 1992a; 2002).

A second relevant element which influences the therapeutic process and its outcome is therapeutic alliance. It includes empathy, warmth, and acceptance, and is regarded as one of the common factors which most strongly affect therapeutic outcome or patient recovery, accounting for 30% of the variance (Lambert, 1992a, 2002).

Another common factor for Lambert (1992a, 2002) is patient hopes and expectations, which accounts for 15% of the variance of the change.

Studies on psychotherapy effectiveness have shown that common variables related with the patient, the therapist, and the interaction between the participants account for the highest percentage of psychotherapeutic change (Botella & Feixas, 1994; Horvath and Symonds, 1991; Lambert, 1986, 1992b).

As the literature shows, common factors have been considered by a number of authors to be ingredients or elements which have a positive or negative impact on the therapeutic process and its outcome, and which are shared by all psychotherapies. The present study paid attention to two of these factors: the therapeutic alliance and psychotherapy expectations.

Psychotherapy expectations

For over 50 years, research has shown that patient expectations are variables which influence the course of the psychotherapy, and have been regarded as a common factor in all psychotherapeutic approaches (Greenberg, 2006).

Expectations are a construct which has been taken into account in motivation theory, social learning theory, and action theories (Carver & Scheier, 2001; Schulte, 2008). In general, expectations are regarded as cognitions about a probable future condition or event (Arknof, Glass & Shapiro, 2002).

Several studies have identified expectations as one of the five factors which influence and are responsible for the therapeutic process and outcome, and which are equivalent across different approaches (Barker, Funk, & Houston, 1988; Dew & Bickman, 2005; Frank, 1973; Greenberg, Constantino, & Bruce, 2006; Stevens, Hynan, & Allen, 2000; Weinberger & Eig, 1999).

It must be pointed out that expectations can point to concordance or discordance between what people expect from the therapy and what actually happens; so, they are regarded as conditions that lead to the success or failure of the psychotherapy (Stiles, Shapiro & Elliott, 1986; Navarro, Schindler & Silva, 1987).

For Frank (1982), unspecific common factors are elements which are more important than therapeutic techniques for attaining a positive psychotherapeutic outcome. He and other authors have suggested that both hope and positive expectations are key to therapeutic outcomes (Ahn & Wampold, 2001; Grencavage & Norcross, 1990; Wampold, 2001).

Several scholars have suggested that patient expectations affect a number of aspects of the therapeutic process, including treatment length, dropout, and treatment outcomes (DeFife & Hilsenroth, 2011; Manzi, Duque, Krebs & Aninat, 1982; Zalaquett).

Factors such as motivation towards the treatment can also be observed through expectations, which reflect the patient's willingness to deliberately participate in the treatment (Norcross, Krebs, & Prochaska, 2011).

Treatment credibility is similar to expectations, but refers to how logical the treatment appears to the patient in order to achieve a certain given objective. The credibility the patient assigns to the treatment influences his/her expectations, but they are different concepts (Devilly & Borkovec, 2000).

In the context of the psychotherapy, patient commitment can be influenced by expectations of control, effectiveness, and a positive result, which can facilitate active participation, whereas negative expectations may result in a more passive role. Patients who contribute to therapeutic change and become more actively committed, from a theoretical point of view, are more likely to show improvement than those who "expect the experts to do all the work" (Arnkoff, Glass, & Shapiro, 2002).

Types of expectations in psychotherapy

Expectations can refer to the following aspects: treatment, role, effectiveness, control and outcome (Arknof, Glass & Shapiro, 2001, 2002).

Treatment expectations refer to the patient's ideas about how the therapy will be conducted, how long it will be, and what the therapist will do or say about his/her concerns (Greenberg, Constantino & Bruce, 2006).

Role expectations are those which focus on the expected or proper role of the patient or the therapist during the treatment. They reflect a perspective about how a person who occupies a certain position must behave while in that position (Arnkoff et al., 2002).

Effectiveness expectations are people's beliefs about what they must do in the therapy or when they return home (Mussell, Fulkerson, Mitchell, Crosby, Hoberman & Romano, 2000).

Control expectations have generally been conceptualized as a trait derived from the patient's own history concerning the influence of personal efficacy and inefficacy in multiple life experiences. They differ from outcome expectations in that a specific action may lead to a

specific result: a patient may expect an excellent outcome, however, he/she believes that therapeutic change does not depend on his/her own efforts (Delsignore & Schnyder, 2007).

Outcome expectations refer to the consequences for the patient of undergoing a certain treatment or therapy. They are also an anticipation of success or global positive changes resulting from the therapeutic process. They refer to recovery expectations, and thus describe the strength of the patient's belief that the therapy will help him/her to feel better. Outcome expectations reflect the patient's general trust in the effectiveness of the treatment, expected recovery, and therapeutic change (Delsignore & Schnyder, 2007).

Specifically, the present research will study the outcome expectations of patients with a depression diagnosis in Chile and Germany before starting their psychotherapeutic treatment. This variable will be probed in association with the therapeutic alliance, depression levels, and specific cultural variables in depressed women in both countries.

Outcome expectations

Several authors have noted that outcome expectations represent a patient's prognosis of the personal effectiveness of the treatment, his/her cognitions about a probable future event or situation, and his/her expectations about the consequences of starting a certain therapy or undergoing a specific treatment (Schulte, 2008; Constantino, Glass, Arnkoff, Ametrano & Smith, 2011).

In addition, positive change expectations and outcome expectations are believed to be powerful common factors linked with patient response to treatment (Arnkoff, Glass, Shapiro, & Norcross, 2002).

They not only include expectations of a positive outcome (recovery expectations), but also of potential negative results (including fear of change) (Carver & Scheier, 2001; Heckhausen, 1991). In psychotherapy research, the concept of outcome expectations has been used to point out the potential benefits of the treatment, but only rarely has it served to display its negative effects (Schulte, 2008).

The literature details two prototypical kinds of expectations: outcome expectations—which include people's forecasts, beliefs, and feelings about the effectiveness of the treatment

(Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011) and the belief that recovery is possible and that therapy will generate a change (DeFife & Hilsenroth, 2011; Frank, 1961; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Kuyken, 2004).

Outcome expectations, one of the central variables in this study, refer to the patient's improvement expectations and to how strongly he/she believes in the therapy's ability to help him/her feel better; alternatively, they may point to his/her overall faith or optimism about the treatment's effectiveness or the expected recovery (Arnkoff, Glass, & Shapiro, 2002).

Schulte (2008) notes that expectations about treatment effectiveness can exist before starting the psychological treatment. Considering the above, this study measured outcome expectations before the patient's therapy began. The instrument used was a questionnaire which measures the patient's prediction of the likelihood of consequences, benefits, negative effects, and potential side effects resulting from the psychotherapeutic treatment. These outcome expectations are represented as a construct consisting of three different elements: hope of recovery, fear of change, and treatment suitability (Schulte, 2005, 2008).

One of the elements of outcome expectations is hope of improvement, which refers to the reduced hope that patients usually display before starting the psychotherapeutic process; therefore, it is a relevant aspect which the therapist can foster and strengthen when the psychotherapy begins, along with change expectations (Reiter, 2010).

Castelnovo-Tedesco & Pietro (1998) have stated that fear of change is a chain of concern-related attitudes about the therapeutic situation and its effects. These authors also mention that it can be an attitude similar to fear of the treatment.

The construct of the patient's impressions about treatment suitability refers to the degree to which he/she deems the therapy offered to be adequate for solving his/her problems (Schulte, 2008).

Outcome expectations are the most extensively studied form of patient expectations in psychotherapy research. Several studies have focused on outcome expectations as global anticipations of success or positive change through the therapy; however, more recent studies have striven to define outcome expectations in connection with behavioral changes or

symptoms (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Joyce, Ogrodniczuk, Piper, & McCallum, 2003; Mussell et al., 2000).

Evidence shows that patients with high outcome expectations benefit more from the psychotherapy than those who do not believe that it will help them to recover. Likewise, there is a significant association between expectations and recovery in psychotherapy (Delsignore, 2007).

In short, it is evident that expectations before the start of the treatment influence its development. According to Beutler (1983), expectations are an element that can guarantee the patient's initial commitment; thus, at the start of treatment, the therapist must be capable of creating a connection between his/her early interventions and the patient's initial expectations.

It is also important to highlight, in the context of the present study, that the culture influences the patient's expectations (Krause, 2005). Before the patient starts his treatment, he will have expectations which are influenced by his/her knowledge of the psychotherapeutic treatment received by neighbors or friends or his/her own prior experience with psychological therapy (Schulte, 2008). Thus, through expectations, the culture also impacts psychological care seeking behaviors (Krause, 2005).

For Berry, Poortinga, Segall & Dasen (2002) and Higginbotham (1977), both the system of personal beliefs that the patient brings into the therapy and cultural practices in society have a bearing on the therapeutic process.

On the other hand, the literature mentions that the therapeutic alliance, another of the central variables in the present study, is also affected by expectations (Gaston, Marmar, Gallagher & Thompson, 1989).

Likewise, Castonguay, Constantino, & Holtforth Grosse (2006), Hatcher & Barends (1996), and Horvath, Del Re, Flückiger, & Symonds (2011) state that expectations influence the quality of the alliance and that they are a relevant factor in the quality of the collaboration, coordination, and affective bond between patient and therapist.

A study about improvement expectations found that positive outcome expectations were associated with patients who developed a positive alliance with their therapists, in the

form of a better work relationship. The authors observed that a good relationship mediated the connection between positive outcome expectations and the therapeutic alliance, and that a better alliance predicted symptom reduction. The study concludes that patients with positive expectations before the start of the psychotherapy were more actively committed to it and engaged in constructive cooperation during therapeutic tasks, which resulted in a good therapeutic alliance (Meyer, Pilkonis, Krupnick, Egan, Simmens & Sotsky 2002).

Influence of depression on patient expectations

The association between expectations and therapeutic outcomes is also empirically supported in the specific case of depression—a diagnosis required to participate in the present study. For example, a meta-analysis carried out by Constantino, Arnkoff, Glass, Ametrano, & Smith (2011) demonstrated that early outcome expectations have a small but significant positive effect on patient response to treatment in several disorders and treatment approaches, including depression.

Empirical findings about the relationship between outcome expectations and response to treatment have showed that higher outcome expectations are associated with recovery in depression treatment (Rutherford, Wager, & Roose, 2010).

Schulte (2008) conducted a study in which he used the Patient Expectations Evaluation Questionnaire (change expectations, fear of change, and treatment suitability) (PATHEV), the same instrument employed in the present research.

The scales in this instrument were correlated with therapy outcomes in patients with various types of disorders, such as anxiety and depression, who were under cognitive-behavioral treatment. This study showed that, at the start of treatment, depressive patients were more pessimistic, were more critical of the treatment's suitability, had less hope of recovering, and displayed more fear of change.

Depressive patients with or without a concurrent anxiety disorder displayed less trust in the therapy, more fear, and more negative effects than undepressed patients(Schulte, 2008).

Another study which explored the association between expectations and depression describes that, in depression sufferers, recovery expectations were linked with recovery probabilities and with low depression severity (Sotsky, Glass, Shea, Pilkonis, Collins & Elkin, 1991).

Therapeutic alliance

Definition

The concept of alliance deviated from its psychodynamic theoretical roots, and became a common factor in psychology, widely popular and extended in psychotherapy research. The term itself dates back to the middle period of Freud's writings, during which he worked on the role and function of transference in psychotherapy (Horvath, 2011).

The meaning of the concept has changed and has not been clearly defined, with its function and effect in the therapy remaining partly controversial (Krause, Horvath & Altimir, 2011).

Several authors (Grencavage & Norcross, 1990; Hovarth & Symonds, 1991) have reported that the therapeutic alliance is the common factor most frequently mentioned in the literature, and that it is positively associated with therapeutic effectiveness in all psychotherapeutic treatment types.

The importance of the therapeutic alliance has been widely recognized in clinical practice and in the theoretical field (Catty, 2004). Likewise, empirical evidence has shown that the alliance is one of the most powerful therapeutic outcome predictors (Horvath & Symonds, 1991).

Generally, the therapeutic alliance has been defined as a component which reflects the quality of the relational interchange between therapist and patient. Most definitions highlight the importance of collaborative commitment in the therapeutic process within the context of a positive attachment (Constantino, Castonguay, & Schut, 2002).

For Horvath (2001, 2011), the concept of alliance stresses conscious aspects of therapeutic work and the collaborative patient-therapist relationship. The alliance includes

positive affective bonds such as respect, mutual trust, and commitment to the therapeutic goals.

For Corbella & Botella (2003), elements such as expectations, opinions, the patient-therapist relationship, the participants' mutual perception, and their personal histories can be relevant elements leading either to the good or the bad state of the therapeutic alliance.

Bordin's contribution

In the present study, the working alliance is understood—according to Bordin's pan-theoretical notion (1976, 1979)—as an entity comprising three inter-related components which determine its quality: agreement on the treatment's goals and tasks and the development of the patient-therapist affective bond. Even though Bordin (1976) regards the alliance as an integrated relationship, he identifies three constitutive components which, taken together, define the quality and the strength of every alliance.

The first component (tasks) refers to the actions and thoughts during the therapeutic process, including the patient-therapist agreement regarding the goals of the psychotherapy as well as their cooperation and collaboration in the activities conducted during it. Tasks represent the collaboration between the patient and the therapist in the activities conducted during the therapy, as well as their agreement and the work to be carried out in the psychotherapeutic process.

The second element (bond) represents the therapist-patient relationship. In addition, it involves their mutual respect and care.

The final element (goals) focuses on the participants' mutual agreement regarding the moment or objectives of the activities. These goals can depend on the problem and the theory employed by the therapist. They refer to the agreement reached by the therapist and the patient regarding the objectives of the psychotherapy (Bordin, 1976, 1979).

In this context, the alliance emerges from the coordination of several elements, such as collaboration in the work conducted by therapist and client, as well as the attention paid to the client's personal resources, capacities, and expectations. Also, it must be pointed out that

elements such as therapeutic tasks and expectations are relevant for the construction of the alliance in the first stage of the therapy (Horvath, 2001).

Early alliance and alliance from the patients' perspective

The present study focused on studying the early therapeutic alliance, since research shows that the therapeutic alliance established at the start of the treatment appears to be a better outcome predictor than alliance assessments conducted in the middle or final phases of the therapeutic process. Evidence reveals that early therapeutic alliance predicts psychotherapy outcomes, and that it is an especially good outcome predictor when measured early in the treatment (Castonguay, Constantino, Holtforth & Grosse, 2006; Horvath 2005, 2011; Martin, Garske & Davis, 2000).

In this regard, the empirical literature also mentions that the early alliance is a powerful factor which influences the patient's commitment to the therapy and its outcome (Strauss, Johnson, Newman, Brown, Barber, Laurenceau & Beck, 2006).

The available evidence has shown that the alliance, measured from the patient's perspective during an early phase in the process, is a relevant predictor of psychotherapy outcomes (Castonguay, et al., 2006). Likewise, studies have identified a positive association between the alliance measured during an early stage and recovery expectations. They report that high recovery expectations promote a high quality early alliance (Conolly, Crist-Christoph, de la Cruz, Barber, Siqueland & Gladis, 2003; Constantino, Arnow, Blasey & Agrass, 2005).

Although the present research does not intend to study therapy outcomes, it must be stressed that it followed the aforementioned evidence in order to look into the first phase of the therapy, that is, the early therapeutic alliance measured during the first and third sessions of the therapeutic process.

According to Bordin (1979), Horvath & Symonds (1991), Horvath, Del Re, Flückiger & Symonds (2011), and Martin et al. (2000), the alliance is a key aspect which positively correlates with psychotherapy outcomes; in addition, the connection between a good therapeutic alliance and a positive outcome plays a significant role in every psychotherapeutic

approach. Similarly, for various diagnosis and population types, the empirical evidence shows an association between the therapeutic alliance and therapy outcomes (Castonguay, Constantino, & Holtforth, 2006).

Studies on alliance and depression

A number of studies have been conducted on the influence of alliance quality on the remission of depressive symptoms (Barber, Conolly, Crits Christoph, Gladys, & Siqueland, 2000; DeRubeis & Feeley, 1990).

A study on chronic depressive patients, conducted by Arnow, Steidtmann, Klein, Rothbaum, Fisher, Constantino, Markowitz, Thase & Kocsis (2013) examined the association between the early therapeutic alliance and changes in depressive symptoms in cognitive-behavioral therapies. The researchers found that a high-quality early therapeutic alliance was connected with a decrease in depressive symptoms. They concluded that the quality of the therapeutic alliance can predict the outcome of several types of treatments for chronic depression, and that the therapeutic alliance is more strongly related with more directive treatments.

In another study, carried out by Webb, DeRubeis, Hollon, Dimidjian, Amsterdam & Shelton (2012) using a population of 105 women aged 40 on average, in two depression treatments part of randomized clinical trials, an analysis was conducted to examine the therapists' adherence to specific behavioral therapy techniques (Collaborative Study Psychotherapy Rating Scale), alliance quality (Working Alliance Inventory, WAI), the prediction of the patient's use of cognitive-behavioral therapy skills (Performance of Cognitive Therapy Strategies), and changes in depressive symptoms (Beck Depression Inventory, BDI) in two independent samples. In general terms, the results indicated that cognitive-behavioral therapy techniques were strongly associated with patient skill in applying cognitive therapy strategies; also, the alliance was found to influence changes in depressive symptoms.

Taking into account the empirical evidence above, a relationship between depression and the therapeutic alliance can be said to exist. As a result, this study looked into the influence of depression levels on the alliance of women with depression in Chile and Germany.

Culture and transcultural research

Culture is composed of values, beliefs, norms, customs, and behaviors shared by the members of a society, and are transmitted over the generations through learning (Cohen, 2009; Triandis, 1994). It springs from adaptive interactions between human beings and their environment, and is made up by shared elements. It is transmitted through time periods and over the generations (Cohen, 2009).

Several conceptualizations of culture exist. For Kroeber & Kluckhohn (1952), Malinowski (1975), and White (1975), culture is based on the experience of a society, which is transmitted to future generations, and consists of implicit and implicit behavior patterns inherited through symbols. For these authors, culture includes traditions, ideas, and values derived from history. In addition, it is made up by the beliefs, art, customs, morals, and habits acquired by human beings.

For example, for Matsumoto & Juang (2012),

> "We define culture as a dynamic system of rules, explicit and implicit, established by groups in order to ensure their survival, involving attitudes, values, beliefs, norms, and behaviors, shared by a group but harbored differently by each specific unit within the group, communicated across generations, relatively stable but with the potential to change across time." (p.10)

On the other hand, the cultural context has been defined as the geographical space, socio-economic environment, political setting, and historical time in which interactions between subjects and objects occur. Cultural contexts and phenomena are neither monolithic nor homogeneous, but they are complex and dynamic; they are a set of interaction factors which influence the therapeutic process and which can be altered by the therapeutic relationship (La Roche & Maxie, 2003). The influence of the cultural context is consistently present in the psychotherapeutic process, although it is often not perceived (La Roche, 2005).

Transcultural research, for its part, is the inclusion of individuals from different cultural backgrounds. This type of research not only tests similarities or differences in behavior, but also the possible limitations of our traditional knowledge by studying people from different cultures. For this reason, transcultural research involves probing the differences between participants from different cultures. It seeks to understand both universal psychological principles and truths valid for people from all cultures) and specific ones (valid only for some people from some cultures) (Matsumoto, 2012).

The findings resulting from the present study will suggest, after analysis and observation, which other types of cultural or contextual variables (as in unpacking study) should be considered in order to gauge their influence on the psychotherapeutic process and create future lines of research (Matsumoto et al. 2012).

Specific Cultural Variables

The present study considered three specific cultural variables: dependent and interdependent self-construal, traditional or egalitarian sexual role ideology, and the rigidity/laxness of familial and social norms. The study looked into how these variables relate with outcome expectations and the early therapeutic alliance (first and third session) in women from two different cultural contexts: Chile and Germany.

Dependent and Interdependent Self-construal

The self-construal cultural variable refers to the individual sense of self in its relationship with others. There are two types of self-construal: one is independent and the other interdependent. They influence and determine the nature of individual experience. These concepts are linked with theories referring to individualism and collectivism. In individualistic cultures, a person's tendency is to have an independent self-construal, whereas in collectivist cultures the interdependent self-concept predominates according to Hofstede (1980), Markus & Kitayama (1991), Matsumoto & Juang (2012), Singelis (1994), and Triandis (1995).

Self-construal helps to predict and explain cultural differences in terms of cognition, emotion, and communication, and is regarded as an individual-level cultural orientation. Self-

construal mediates and explains the effects of culture on a variety of social behaviors (Markus & Kitayama, 1991).

Self-construal focuses on two aspects of one's idea of oneself: that which people "believe about the relationship between the self and others and the degree to which they see themselves as separate from others or connected with them" (Markus & Kitayama, 1991, p. 226).

Markus & Kitayama (1991) propose that the independent and interdependent self-construal are an individual-level explanation of the cultural differences based on perception, motivation, and behavior. Research on self-concept has mainly focused on how individuals in all cultures differ.

Hofstede (1980) regarded Chilean society as a chiefly collectivist country, in which the prevalent conceptualization is interdependent, in contrast with Germany, which for this author is mostly individualistic and has a mainly independent self-concept.

However, some studies mention that Chile, despite having had a historically collectivist culture, has in recent years displayed leanings towards both types of self-construal. In this regard, Fernández, Dawn, Carlson, Stepina & Nicholson (1997) noted that studies on these variables in Chile have shown that collectivism is retreating, and that has individualism has started emerging in its place.

A study conducted by Kolstad & Horpestad (2009), which compared a Chilean and a Norwegian sample, investigated the independent and interdependent self-concepts in them. They found that both Chileans and Norwegians scored significantly higher for independence than for interdependence. This is consistent with another study about these dimensions in the general Chilean population, which recorded high scores both for the independent and interdependent self-concepts. The research concluded that this is the result of economic growth, political changes, values, and greater female participation in the job market (Olhaberry, Crempien, Biedermann, Cruzat, Martínez, V., Martínez, F., & Krause, 2011).

Triandis (1989) explains that, due to modern industrial environments, neo-individualism has emerged. In it, a small group, the family or a group of co-workers, plays an

important role in behavior determination, but the individual retains considerable freedom of action outside of the group. Therefore, it can be stated that Chilean culture is collectivist in some aspects but individualistic in others (Triandis, 2011).

Markus & Kitayama (1991) note that:

> "Construals of the self, of others, and of the relationship between the self and others may
>
> (…) their influence is clearly reflected in differences among cultures. (…) . The independent view is most clearly exemplified in some sizable segment of American culture, as well as in many Western European cultures. The interdependent view is exemplified in Japanese culture as well as in other Asian cultures. But it is also characteristic of African cultures, Latin-American cultures, and many southern European cultures. We delineate how these divergent views of the self—the independent and the interdependent can have a systematic influence on various aspects of cognition, emotion, and motivation. Furthermore, for those with interdependent construals of the self, both the expression and the experience of emotions and motives may be significantly shaped and governed by a consideration of the reactions of others" (pp. 224-225).

These authors explain that:

> "Achieving the cultural goal of independence requires construing oneself as an individual whose behavior is organized and made meaningful primarily by reference to one's own internal repertoire of thoughts, feelings, and action, rather than by reference to the thoughts, feelings, and actions of others" (p. 226).

People with a more independent self-concept can be motivated by actions which allow them to express themselves. It is important for them to define their internal attributes by being hard-working, independent, and powerful. They regard the self as something distinct from collectives; also, their own internal attributes, such as preferences, skills, and attitudes are distinguished from those of others, and thus they attain their own goals. The cultural ideal in this type of self-concept is to separate oneself, generally, via competition. The idea of self, in individualistic cultures, gives importance to values such as autonomy, competition, freedom, independence, assertiveness, and confrontation (Markus & Kitayama, 1991; Schwartz, 1994; Triandis, 1988; Triandis & Gelfand, 1998).

Singelis (1994) points out that the independent self-concept emphasizes internal capacities, thoughts, and feelings, uniqueness, self-expression, awareness of one's internal attributes, the advancement of one's objectives, and directness in communication.

Individuals with an interdependent self-concept tend to wish to fit in with others, often see themselves as connected, and, in general, have to take part in several interpersonal relationships; also, they tend to act following others' expectations rather than their own wishes. (Markus & Kitayama, 1991).

"Experiencing interdependence involves seeing oneself as part of a global social relationship and recognizing that one's behavior depends on, is determined by, and is organized to a large extent according to what the participant perceives as the thoughts, feelings, and actions of others in relationships" (Markus & Kitayama, 1991) (p. 227).

Singelis (1994) has stated that the interdependent self-concept emphasizes external traits such as the public sphere, roles, status, and relationships, along with indirect communication and the "reading" of others' minds. Harmonious interpersonal relationships and the ability to adapt to different situations are a source of self-esteem in this self-concept type. It must be pointed out that individuals with this self-concept tend to be socially, focus on norms, rules, duties, and obligations, and be more formal, which is typical of collectivist cultures (Davidson, Jaccard, Triandis, Morales, & Díaz-Guerrero, 1976; Kashima, Siegel, Tanaka, & Kashima, 1992).

Notably, Frank (1991) mentions that psychotherapy appears to be more useful for people with a greater ability for establishing closer, trusting relationships, who are more sociable, and who take interest in group activities. This may be related with a leaning towards the interdependent self-concept in the patient receiving treatment. In this respect, Markus & Kitayama (1991) and Hofstede (2001) mention that more interdependent people tend to wish to be connected with others, are part of several interpersonal relationships, and act according to other people's expectations rather their own desires.

Traditional and Egalitarian Sexual Role Ideology

According to Matsumoto et al. (2012), the term "sex" makes reference to biological and psychological differences between men and women. Sexual role, for this author, is associated with the expected behaviors of men and women in connection with their biological differences. Gender, in contrast, refers to the culture's influence on the behavior of men and women through sexual differences. A person's gender role is the degree to which he/she adopts specific behaviors such as the stereotypes established by the culture. Gender role ideology refers to judgments about what gender roles must be in a certain given culture.

The present study took into account the *sexual role ideology* cultural variable, which alludes to the roles and behaviors of men and women (Kalin & Tilby, 1978).

The *sex role ideology* variable has two dimensions: the traditional and the egalitarian ideologies. These dimensions are important in psychology due to their association with self-definition and their influence on the way in which men and women interact and establish interpersonal relationships. The traditional sexual role ideology characterizes women as subordinate and inferior to men in different areas, such as intelligence and assertiveness. This type of ideology places the male in the role of provider. On the other hand, the egalitarian ideology is characterized by a tendency to seek equality in personal and work relationships (Espiritu, 1999; Ruth, 1990). More traditional points of view about the role of women prioritize marriage and procreation over a profession; also, women displaying this predominance give more importance to showing a shier personality (Ruth, 1990; Jenkins & Aube, 2002).

In contrast, women with an egalitarian ideology tend to have a more confident and independent interpersonal style. Non-traditional women also reject traditional cultural ideals and tend to seek fulfillment in professional careers; they desire equality in everything, and display behaviors that challenge traditional norms (Ruth, 1990).

According to Matsumoto & Juang (2012), gender role ideology is a relevant subject which has been studied in all cultures and which has been found to take two general forms: that men and women should be equal or that there are certain things that they must do. To examine gender role ideologies, Williams & Best (1990) applied a scale that described them in 14 countries. The scale generated scores between opposing poles, labeled "traditional" and "egalitarian". They mention that the most egalitarian scores were found in countries such as the Netherlands, Germany, and Finland, whereas the most traditional ideologies are present in Nigeria, Pakistan, and India. They also found that the greater degree of individualism observed in the more egalitarian scores was associated with living in a socio-economically advanced country, with a high rate of Protestant Christians, a low rate of Muslims, and a large percentage of women working outside of the home and enrolled in universities.

Tightness and looseness of social and familiar norms

Another cultural variable studied was the tightness or looseness of social and familial norms. A number of authors have noted that the construct of rigidity versus laxness is relevant for differentiating societies. For example, a culture with more rigid social and familial norms will be characterized by being closed to external influence and displaying a strong adherence to social norms; in contrast, "loose" cultures are those in which rules and discipline are scarce and there is a tendency to tolerate deviant conduct. These cultures are less prone to group organization and solidarity. More rigid cultures have clear rules; society behaves in a strict and disciplined way, with a tendency to impose heavy sanctions on those who fail to observe the norms (Pelto, 1968; Triandis, 1989).

Gelfand, Raver & Nishii (2006) have suggested that the rigidity and laxness of societal norms involve two chief components: their strength, that is, how clear and strong norms and sanctions are in a given society, and the prevalence of noncompliance. The construct of rigidity versus laxness refers to how behavior is influenced by the strength of social norms

(their number and clarity) and of sanctions (tolerance of noncompliance with the norms) (Gelfand et al 2006; Triandis, 1989).

Countries such as Brazil are generally collectivist and loose; others, such as Japan or Singapore, are collectivist and rigid, while others can be individualistic and lax, such as The United States and New Zealand, or individualistic and tight, like Germany (Chan, Gelfand, Triandis & Tzeng, 1996; Triandis, 1989).

There are differences between tight cultures (many strong norms and low tolerance of deviant behavior) and loose ones (weak social norms and a high tolerance of deviant behavior) (Gelfand et al., 2006).

Empirical studies on specific cultural variables

Olhaberry, Crempien, Biedermann, Cruzat, Martínez, V., Martínez, F. & Krause (2011), in a study about the specific cultural variables *Dependent/Interdependent Self-Concept*, *Traditional/Egalitarian Sex Role Ideology*, and *Tightness/Looseness of social and familial norms*, conducted in the general Chilean population, found high scores for both the independent and interdependent self-concepts. They concluded that this phenomenon may be the result of economic growth, political changes, new values, and greater female participation in the Chilean job market.

Likewise, the results of this study showed that young women displayed a more egalitarian sex role ideology than older women. The study also revealed that people with an egalitarian sex role ideology scored lower for interdependent self-concept. In addition, the results showed that the more egalitarian a person's sex role ideology, the lower the norms' tightness. The individuals who displayed a more egalitarian ideology were more flexible concerning their social and familial norms and less interdependent.

In conclusion, previous findings in Chile have demonstrated that interdependence is accompanied by more tightness in familial norms and sanctions. In Chile, familial norms were shown to be tighter than social norms. People with a higher SES displayed less equality in their sex role ideology.

The high scores for familial norms observed in Chile may be related with economic factors, familial structure—the head of household is often female—as well as with traditional religiosity and the priority of the family as a value.

On the other hand, the main conclusions of the application of the Multidimensional Battery of Cultural Variables (Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer, 2010 [HKFB]) in Germany was that TLS scales (social and familial Tightness-Looseness Scales) were negatively correlated with the SRIS (Sex Role Ideology) and positively correlated with the SCS (interdependence scale). The SRIS was negatively correlated with the SCS for interdependence. The researchers concluded that familial norms were significantly associated with higher age, less education, and severe depression. The effect of sex role ideology was observed to be stronger in women than in men. The negative correlation between the SCS and the BDI confirms the assumption that the independent self-concept has adaptive effects in western societies.

In the same study, it was observed that higher-SES individuals in Germany displayed more egalitarian ideologies than in Chile, where a higher SES was associated with a more traditional ideology (Freund, 2010).

Sex Role Ideology Research

In a study aimed at analyzing the *sex role ideology* variable, Williams & Best found that more egalitarian scores were predominant in countries such as Germany, which enjoy high rates of economic development and have a large percentage of female university graduates who work outside of the home. Therefore, more individualistic countries tend to gravitate towards more liberal sex role ideologies (Williams & Best, 2001).

Concerning the same variables, a study conducted with female and male inpatients, aged 36 on average, indicated that women displayed a stronger tendency towards an egalitarian ideology than men (Steinberg, Leicher & Harper, 1987).

Declan, Barry & Beitel (2006) studied the relationship between ethnic identity, self-concept, acculturation, and mental health in Southeast Asian immigrants to the United States. Male participants displayed an interdependent self-concept and a more traditional sex role ideology,

whereas women presented a more independent self concept and a more egalitarian sex role ideology. The authors attribute the differences between men and women to the length of the participants' residence in the United States. They note that the men who had spent only a few years in the country still displayed a tendency towards collectivism and the more traditional sex role ideology that characterizes eastern cultures.

In general terms, the studies cited above concluded that more egalitarian sex role ideologies were predominant in countries with high economic development rates such as Germany. In addition, they noted that women, aged 36 on average, display a stronger tendency towards an egalitarian ideology than men. Likewise, the findings showed that interdependent self-concept and traditional sex role ideology were more prevalent in men than in women, who reported a more independent self-concept and a more egalitarian sex role ideology.

Research on independent-interdependent self-concept in connection with depression

A study conducted by Mak, Law & Teng (2011) analyzed the association between self-concept, anxiety, depression, and sociotropy, which according to Beck's theory is a dimension of personality that includes attitudes and beliefs involving a heightened consideration of interpersonal relationships and high emotional dependence on others.

Two groups were studied: one Asian-American and one European-American. The researchers observed that the interdependent self-concept was negatively associated with depression, and that the independent self-concept protects people from developing sociotropy and experiencing anguish.

Chang (2013) studied the difference between perfectionism, loneliness, and self-concept as the sole predictors of depressive and anxious symptoms in an Asian-American and a European American sample. The results showed that, in both groups, self-concept predicted depressive but not anxious symptoms. The study used the SCS and the BDI-I.

Depression

What is depression?

According to WHO (2014):

"Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration Depression can be long-lasting or recurrent, substantially impairing an individual's ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide. When mild, people can be treated without medicines but when depression is moderate or severe they may need medication and professional talking treatments. Depression is a disorder that can be reliably diagnosed and treated by non-specialists as part of primary health care". http://www.who.int/topics/depression/es/

Depression and women

Depressive disorders have existed since ancient times; Kaplan & Sadock (1999) state that descriptions of them can be found in extremely old texts. The behavior and characteristics of the depressive syndrome are influenced by its persistence, the gravity of the symptoms, the patient's perception of conflicts, socio-demographic characteristics, personality factors, secondary gains associated with the patient role, and the way in which problems are dealt with (Caraveo, Martínez, Rivera & Polo, 1997).

For Jiménez (2003), the depressive disorder takes the form of a mood which can be recognized as a set of negative emotions, such as sadness. Patients with depression often have a pessimistic perception of themselves, of their relationships with the social environment, and of their future prospects.

In addition, depression sufferers display anxiety and impotence. The thoughts of depressive patients are frequently negative and are indicative of low self-esteem. Individuals diagnosed with this disorder generally lose interest in everyday activities and in their hobbies, do not dare to make decisions, isolate themselves socially, and become dependent on others.

Major depressive disorder can be accompanied by symptoms such as chest tightness, sleeplessness, hypersomnia, psychomotor retardation, loss of appetite, weight gain, and decreased sex drive. Depression can range from mild to very severe, is often episodic, recurrent, or chronic, with episodes lasting from months to years interspersed with periods of normality (OMS, 2001).

Major Depressive disorder is identified with states of sadness, accompanied by a number of symptoms and signs which persist for at least 2 weeks (MINSAL, 2009).

According to Lewinsohn, Rohde, & Seeley (1993), depression can occur at any point of a person's life, although its incidence is higher in maturity. Nevertheless, they also mention that depression can be identified in adolescents and young adults.

Depression is more common in women than in men (WHO, 2001), and is the world's third most prevalent disease, occupying the eighth place in high-income countries and the first in low and medium-income countries. Among women, it accounts for the largest proportion of disease burden in high, medium, and low-income countries (Murray & López, 1997; Araya, Rojas, Fritsch, Acuña & Lewis, 2001; WHO, 2008).

This mood disorder constitutes one of the main public health problems in the world due to its high prevalence across age groups and the severe disability that it causes in developed and developing countries (Vicente, Rioseco, Saldivia, Kohn & Torres, 2002; WHO, 2002).

In Chile, according to a study on its disease burden and attributable burden (MINSAL, 2007), unipolar depression is the second cause of lost disability-adjusted life years (DALYs) in the general Chilean population and the first among women aged 20-44 (Vicente et al. 2002).

In addition, depressive disorders are one of the chief health issues in Chile, with a prevalence close to 10% in the population over 15 years of age (Vicente, 2002; Araya, Rojas, Fritsch, Acuña & Lewis, quoted in Alvarado & Rojas, 2011).

In 2003, WHO estimated that 154 million people around the world suffered from depression and that the burden of depressive disorders was on the rise. According to current predictions, depression will be the main cause of global morbidity by 2030 (WHO, 2011).

A number of studies have shown that this disorder is more prevalent in women than in men, with such differences being present in several cultures. It has been estimated that women suffering from depression outnumber men 2 to 1. Studies conducted in Latin America have displayed the same proportion. However, a study carried out by Vicente et al. yielded lifetime prevalence rates ranging from 1.0 to 3.0 (Kessler et al., 1993; Vicente et al., 2000, 2002).

Depression is more prevalent in women than in men, both in Chile and Germany (Jacobi et al., 2004; Vicente, Rioseco, Saldivia, Kohn & Torres, 2002).

Factors such as anxiety, depression in childhood, hardships during adolescence, stressful life situations and the capacity to tackle them, biological aspects, and a lack of social support are elements which predispose women to depression (Brown, 1978). Likewise, biological, social, cultural, and economic aspects are regarded as factors which trigger depression (Sheeline, Wang, Gado & Kraemer, 2003).

Some authors mention that women are more likely to experience emotional problems than men due to the social roles that the former play in their lives. The reasons they advance are that men tend to have work and family as sources of satisfaction, whereas women usually spend more time with their families, raising children and performing domestic tasks, and sometimes only play the housewife role (Gove & Tudor, 1973; Murray et al., 1997; Patel et al., 1999).

In addition, socially disadvantaged women may be affected by stressful factors thought to influence the high prevalence of mood disorders. Elements such as the traditional role of women in society can result in more exposure to stress; also, gender differences with respect to depression rates may be due to the high rates of domestic and sexual violence to which women are exposed (Araya et al., 2001; WHO 2001).

Having a low income and raising small children have been regarded as possible negative factors which can have a bearing on female depression (Araya et al., 2003; Weissman, 1987).

Finally, another relevant effect has been described in young women suffering from depression during the critical child rearing cycle: the increased work demands associated with

children, along with the gradual reduction of family size, increase the pressure on everyday family life and reduce the support provided by it (Araya, Rojas & Lewis, 2005; Jadresic, 1990; Patel, Araya, Ludemir, Todd & Lima, 1999).

Comparative studies about depression in Chile and Germany

A study conducted by Heerlein, Gabler, Chaparron, Kraus, Richter & Berkau (2000) looked into the differences or similarities of major depression in Chile and Germany. The authors found that the relationship between symptomatology, certain personality traits, and severe major depression display a small degree of variability across cultures; in other words, severe major depression "seems to be a transculturally stable pathological entity, with limited variations in its psychopathological profile and its somatic symptoms".

The above empirical findings are the result of studies that have analyzed the influence of culture on depression, the psychotherapeutic process, and psychotherapy expectations; in addition, other research has focused on the relationship between positive patient expectations before the start of the treatment and high alliance quality, the association between expectations and depression, and the importance of measuring the alliance at an early stage of the psychotherapeutic process. However, few transcultural studies have looked into the association between specific cultural variables and variables of the therapeutic process comparing Chile and Germany or other countries.

This situation prompts the need to assess the influence of culture, in this case, that of specific cultural variables (independent/interdependent self-concept, egalitarian/traditional sex role ideology, tightness/looseness of social and familial norms), on factors common to all therapies, such as expectations and the therapeutic alliance in women with depression living in different cultural contexts: Chile and Germany. Therefore, the present study seeks to provide an answer to the following question: What is the relationship between psychotherapy expectations and the early therapeutic alliance in women with depression in the Chilean and German cultural contexts?

Research problem

What is the relationship between psychotherapy expectations and the early therapeutic alliance in women with depression, in the Chilean and the German cultural contexts?

General Objective

To determine the relationship between psychotherapy expectations and the early therapeutic alliance in women with depression in different cultural contexts (Chile and Germany), exploring the association between these variables and the cultural variables *independent/interdependent self-concept*, *traditional/egalitarian sex role ideology*, and *tightness/looseness of social and familial norms*.

Specific Objectives

1.- To determine the association between psychotherapy expectations and the early therapeutic alliance in women with depression in Chile and Germany.

2.- To determine the association of the variables *independent/interdependent self-concept, traditional/egalitarian sex role ideology*, and *tightness/looseness of social and familial norms* with the psychotherapy expectations of women with depression in Germany and Chile.

3.- To analyze the relationship of the variables *independent/interdependent self-concept*, *traditional/egalitarian sex role ideology*, and *tightness/looseness of social and familial norms* with the early therapeutic alliance of women with depression in Germany and Chile.

Hypotheses

H 1. Patients with a more independent self-concept will display higher expectations in comparison with those whose self-concept is more interdependent.

H1.1 Patients with a more egalitarian sex role ideology will have higher expectations than those with a more traditional ideology.

H 2. Patients with high expectations will establish a better therapeutic alliance than those with low expectations.

H 3. Patients with a more severe level of depression will have higher expectations than those with a mild or moderate level of depression.

H 4. Patients with severe depression will establish a low-quality therapeutic alliance.

H 4.1 Patients with mild or moderate depression will establish a better therapeutic alliance.

H 5. Patients with an interdependent self-concept will establish a better alliance than those with an independent self-concept.

H 5.1 Patients with a tight perception of social and familial norms will establish a better therapeutic alliance than those with a looser perception of social and familial norms.

H 5.1.2 Patients with an egalitarian sex role ideology will establish a better therapeutic alliance than those with a more traditional ideology.

H 6 Patients with severe depression will perceive familial and social norms to be tighter than those with mild depression.

H 6.1 Patients with mild depression will display a more interdependent self-concept than those with moderate or severe depression.

H 6.1.2 Patients with severe depression will display a more traditional sex role ideology.

Method

The general design of this research is non-experimental, exploratory, descriptive, quantitative, correlational, and transcultural. It studied women diagnosed with depression who were receiving psychotherapy, and associated their psychotherapy expectations with the early therapeutic alliance and a set of cultural variables.

Participants

The sample consisted of two groups of patients diagnosed with depression who were receiving psychotherapy, one in Chile and another in Germany. The first group was made up by 46 women, while the other comprised 30 female participants. Their age ranged from 20 to 50 years. The Chilean sample consisted of outpatients contacted at Psicomédica Health Clinic in Santiago, while the German one was made up by inpatients at Heidelberg University Hospital, General and Psychosomatic Medicine Clinic. The samples were selected purposively and non-probabilistically.

Inclusion criteria

The patients included were female, aged between 20 and 50 years, and diagnosed with at least a mild level of depression according to the BDI-I.

Exclusion criteria

Patients with psychotic disorders, eating disorders, and addiction to drugs and alcohol.

Description of the sample

Socio-demographic variables of the Chilean participants

The Chilean participants were 37 years old on average; 45.7% were married when the study was conducted; 37% were single; 13% were divorced; 2.2% cohabited with their partners; and 2.2% were widowed. 56.5% had children, while 43.5% did not.

Concerning their education, 45.7% had attended university, 15.2% had completed their secondary studies; 8.7% had incomplete secondary studies; 4.3% had complete primary studies; 23.9% had completed their technical-professional education; and 2.2% were illiterate.

39.1% of the patients had full-time jobs; 15.2% worked part-time; 6.5% worked occasionally; 23.9% were housewives; 6.5% were students; 2.2 were in training/changing careers; and 6.5% were unemployed (Table 1).

Table 1. Socio-demographic variables of the Chilean participants

Civil status					**Age**
Married	**Single**	**Separate**	**Cohabitant**	**Widow**	
45.7%	37%	13%	2.2%	2.2%	m=37 years
School					
University	**Téchnics**	**Complete Highschool**	**Incomplete Highschool**	**Complete elemnetary school**	**Illiterate**
45.7%	23.9%	15.2%	8.7%	4.3%	2.2%
Children					
Yes	**No**				
56.7%	43.5%				
Work activity					
Full time	**Half time**	**Ocassionaly**	**House wife**	**Student**	**In trainning**
39.1%	15.2%	6.5%	23.9%	6.5%	2.2%
Unemployed					
6.5%					

Socio-demographic variables of the German participants

The German participants were aged 32.5 on average. Concerning their marital status, 40% were single; 30% cohabited with their partners; 16.7% were married; 6.7% were divorced; and 6.7 were widowed.

Regarding their education, 0% had attended university; 36.7% had completed their secondary studies; 40% had incomplete secondary studies; 3.3 had completed their primary education; 6.7% were professional technicians; and 10% were illiterate.

33.3% of the German participants had children, while 67.7% did not. Concerning their work, 33.3% had a full-time job; 23.3% were students; 13.3% had a part-time job; 10% performed other activities; 3.3% were housewives; 3.3% were unemployed; and 2.2% were in training/changing careers (Table 2).

Table2. Socio-demographic variables of the German participants

Civil status					**Age**
Married	**Single**	**Separate**	**Cohabitant**	**Widow**	
16.7 %	40%	6.7 %	30%	2.2%	m=32.5 years
School					
University	**Téchnics**	**Complete Highschool**	**Incomplete Highschool**	**Complete elemnetary school**	**Illiterate**
0%	6.7%	36.7%	40%	3.3 %	10%
Childrens					
Yes	**No**				
33.3%	66.7%				
Work activity					
Full time	**Half time**	**Ocassionaly**	**House wife**	**Student**	**In trainning**
33.3%	13.3%	10%	3.3%	23.3%	2.2%
Unemployed					
3.3%					

Procedure

Patients are admitted into Psicomédica after being referred by a general physician who suspects them to suffer from some degree of depression. Once the patient is admitted, a team of psychiatrists confirms or rules out the presence of the disorder according to DSM-V and the MINI interview (Lecrubier et al., 1997; Sheenan et al. 1998). Afterwards, the patient enters a psychoeducational workshop and/or starts individual psychotherapy at the center.

The treatment provided at Psicomédica follows different psychotherapeutic approaches and is generally brief, consisting of approximately 6 to 12 sessions, each lasting 45 min.

The German participants were inpatients. Prior to their hospitalization, they had been diagnosed with depression by a psychiatrist. Subsequently, they received psychodynamic

psychotherapy as part of their inpatient treatment. They attended the sessions twice a week, averaging 16 sessions during 8 weeks. The patients were contacted and invited to participate in the previous study at the beginning of their psychotherapeutic treatment, at which point the questionnaires were applied. The samples were taken in both countries from June 2012 until July 2013.

Timing of the measurements

The patients' level of depression was measured before the first session using the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, J., 1961 [BDI-I]) in Chile and Germany (Hautzinger, Bailer, Worall & Keller, 1994 [BDI-I]). In addition, to identify the presence of major depression, the MINI International Neuropsychiatric Interview (Lecubrier, Sheehan, Weiller, Amorim, Bonora, Sheehan, Janavs & Dunbar, 1997) was applied in Chile, while the Patient Health Questionnaire for Depression (Spitzer, Kroenke & Williams 1999 [PHQ-D]) was used in Germany.

Outcome expectations were analyzed with the Patients' Therapy Expectation and Evaluation questionnaire [author's translation] (Schulte, 2005 [PATHEV]) in Chile and Germany prior to starting the psychotherapeutic process. Specific cultural variables were measured using the Multidimensional Questionnaire of Cultural Variables (Olhaberry, Crempien, Biedermann, Cruzat, Martínez, V., Martínez, F. & Krause, 2011 [CMVC]) in Chile, and the Multidimensional Battery of Cultural Variables (Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer, 2010 [HKFB]) in Germany.

The therapeutic alliance was measured before the first and third sessions with the Working Alliance Inventory (Santibáñez, 2001 [WAI]) in Chile and the Working Alliance Inventory-Short Revised (Wilmers, Munder, Leonhart, Herzog, Plassmann, Barth, & Linster, 2008 [WAI-SR]) in Germany.

Table 3 shows the moments when data were collected via the application of self-report instruments.

Table 3. Measurements and moment of application of the questionnaires

BDI	**MINI (Chile)**
Applied before the first session	Applied before the first session
PHQ-D (Germany)	**PATHEV**
Applied before the first session	Applied before the first session
Multidimensional battery of cultural variables	**WAI**
Applied after the first session	Applied after the first and third sessions

Measurement methods

Measurement of depression

The BDI–I (Beck Depression Inventory) was used, which is a 21-item instrument. This inventory measures the severity of depressive symptoms (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). Beck noted that the BDI does not reflect any specific theory of depression, but that it only reflects the symptoms that the depressed person has observed in him/herself (Beck, Steer & Brown, 1996). This instrument intends to provide a specific picture of the patient's current mood and feelings. It comprises 21 items, each measuring one symptom; for example, humor, thoughts about the future, failure, satisfaction, among others. Each response is assigned a score from 0 to 3 and grouped into one of four areas: a) Somatic, b) Self-esteem, c) Mood, d) Social. Scores between 0 and 9 indicate minimum depression; 10 - 18, mild depression; 19 - 29, moderate depression; 30 - 63, severe depression. Therefore, higher scores indicate more severe symptoms (Beck, 1979).

In the present study, the version used was the one currently being validated for Chile by the "Psychological Intervention and Change in Depression" Millennium Nucleus (NS100018). In this version of the instrument, each response is assigned a score between 0 and 3, with items being grouped into four areas, a) Somatic, b) Self-esteem, c) Mood, d) Social.

The original version of the BDI displays high internal consistency, with alpha coefficients ranging from .73 to .92, averaging .86 for psychiatric populations and .81 for non psychiatric ones (Beck, Steer, & Garbin, 1988).

In Germany, an equivalent version of the instrument was used, which was validated by Hautzinger, Bailer, Worall & Keller (1994). This version of the instrument has a reliability of 0.79 (Cronbach's Alpha) for healthy controls and 0.92 for young depressive patients under 20 years old. Regarding its validity, the instrument displays high correlation levels with other self-report questionnaires for depression (for example, .89 between the CES-D and the BDI-I).

Measurement of depressive symptomatology

In Chile, the study employed the MINI International Neuropsychiatric Interview (Lecubrier, Sheehan, Weiller, Amorim, Bonora, Sheehan, Janavs & Dunbar, 1997), a structured diagnostic interview that explores the criteria of Axis I of DSM-V and ICD-10. The items are based on the operational diagnostic criteria of these classifications. It is divided into 16 modules identified by letters, which indicate the diagnostic category involved. In the present study, only the depressive symptomatology indicators revealing the presence of major depression were taken into account. The psychometric properties of this instrument display a Kappa coefficient of 0.68 for major depression, 0.86 for sensitivity, and 0.84 for specificity.

In the German sample, the German version of the PHQ-D self-report questionnaire (Spitzer, Kroenke & Williams 1999) was used, which is an instrument for diagnosing, reviewing, and evaluating mental disorders. This instrument was designed to assist psychiatrists and psychologists working in primary health care centers.

Measurement of outcome expectations

The Patients' Therapy Expectation and Evaluation questionnaire, PATHEV (Schulte, 2005), comprises three subscales which measure: a) Hope of Recovery, b) Fear of Change, and c) Treatment Suitability. According to the questionnaire, the presence of more hope of recovery, less fear of change, and a positive perception of the treatment's suitability indicate high patient expectations with respect to the treatment. The questionnaire has a Cronbach's alpha of P = .89 for the Hope of recovery subscale, P = .73 for the Fear of Change subscale; and P= .81 for the Treatment Suitability subscale.

Measurement of specific cultural variables

In Chile, cultural variables were measured with the Multidimensional Questionnaire of Cultural Variables (Olhaberry, Crempien, Biedermann, Cruzat, Martínez, V., Martínez, F. Krause, 2011 [CMVC]). The same instrument, under the name Multidimensional Battery of Cultural Variables (Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer, 2010 [HKFB]), was applied in Germany.

The battery comprises three subscales:

a) The Self Construal Scale (SCS), created by Singelis (1994), comprises 30 items, 15 measuring independence and 15 interdependence. For each item, the subjects manifest their degree of agreement or disagreement with the statement presented using a 7-point Likert scale (1=totally disagree, 7=totally agree). Scores can range from 15 to 105 in each subscale. With a cut-off score of 45 points, higher or lower scores will indicate more independence or interdependence, respectively.

b) The Sex-Role Ideology Scale (SRIS), developed by Kalin & Tilby (1978), showed correlations for all items, with an average r of .79. Test-retest reliability reached .87.

In both countries, the shortened 9-item version (Freund et al., 2010) was used. For each item, the subjects manifest their degree of agreement or disagreement with the statement presented using a 7-point Likert scale (1=totally disagree, 7=totally agree). The scores for the items indicating a traditional tendency are inverted before calculating the total score for the scale.

Scores range from 9 to 63, with a cut-off score of 27 points. Lower scores indicate a traditional ideology, while higher ones indicate an egalitarian sex role ideology.

c) The Tightness-Looseness Scale, Social Version (TLS-S) was developed by Gelfand et al. (2007) and explores, through 6 items, the perceived tightness or looseness of social norms and the weight assigned to social sanctions. The subjects manifest their agreement or disagreement with the statement presented using a 6-point Likert-type format (1=totally disagree, 6 = totally agree). The scores in this scale range from 6 to 36 points, with a cut-off score of 15 points. Higher scores indicate more tightness in social and familial norms, whereas lower ones point to more looseness.

Item 4 scores which indicate looseness are inverted before calculating the total score for the scale. Higher scores indicate more tightness in social norms.

The Tightness-Looseness Scale, Family Version (TLS-F), was adapted for Germany by Freund et al. (2010). Items refer to perceived tightness or looseness in norms and sanctions within the familial. It consists of 6 items with the same response choices and scores used in the TLS-S.

Measurement of the therapeutic alliance

The Working Alliance Inventory (WAI), developed by Horvath & Greenberg (1989), measures the quality of the therapeutic alliance based on a definition advanced by Bordin (1976, 1979), who explains the concept in terms of the compatibility and collaboration between client and therapist in three dimensions: (a) agreement on therapeutic tasks, (b) positive bond, and (c) agreement on objectives. These tasks are the actions and thoughts involved in the therapeutic process; therefore, perceiving such actions or tasks as relevant is a major factor in the establishment of the alliance. Agreement between the therapist and the patient regarding which objectives the psychotherapy should seek is the second variable measured by the WAI. Lastly, the bond between the participants refers to the ability to share mutual trust and acceptance (Corbella & Botella, 2003).

In Chile, the therapeutic alliance was measured using the version validated by Santibañez (2001), the Working Alliance Inventory [Inventario Alianza de Trabajo, IAT],

while the Working Alliance Inventory-Short Revised (Wilmers, Munder, Leonhart, Herzog, Plassmann, Barth, & Linster, 2008 [WAI-SR]) was used in Germany.

Reliability values (Cronbach's Alpha) are between .91 for the IAT version of the patient and the therapist .93, with a moderate convergent validity ranging from .19 to .44 (Santibañez, 2001).

The three forms of the questionnaire comprise 36 items grouped into three subscales: bond, tasks, and goals. Each scale consists of 12 items, with scores being assigned using a 7-point Likert-type scale (1= Never; 7=Always). Total scores range from 36 to 252 points, with high scores reflecting a good-quality alliance.

It must be pointed out that, due to the fact that different scales were used in each country (WAI long form in Chile and WAI-SR short form in Germany), the therapeutic alliance was evaluated considering the 12 items of the Chilean version which match those in the German version. Therefore, the Chilean version of the WAI consisted of 4 items per subscale. The total number of items of each subscale (12) was multiplied by the number of options provided by the Likert scale of this version (7), which resulted in a minimum of 12 points (4 items x 3 subscales) and a maximum of 84 (12 items x 7 options). The scores ranged from 12 to 84 points, which add up to 72 points in total; therefore, one half (36 points) was considered the cut-off score, with higher scores indicating a high-quality alliance and lower ones pointing to a low-quality alliance.

The Working Alliance Inventory Short Revised (Wilmers, Munder, Leonhart, Herzog, Plassmann, Barth & Linster, 2008 [WAI-SR]), German version, comprises 12 items and three subscales that measure the bond, task, and goals, each with four items which can range from 1 (never) to 5 (always).

Hatcher & Gillaspy (2006) reported that the consistency of the scores (alpha coefficients) ranged from .91 to .92 for the total WAI-SR score, .85 to .87 for the goals subscale; .85 to .87 for the tasks subscale; and .85 to .90 for the bond subscale. The German WAI-SR displays good internal consistency (Cronbach's Alpha of the subscales ranging from .81 to .91).

Equivalence and adaptation of the instruments used in chile and germany

To establish the equivalence of the questionnaire that measures outcome expectations (PATHEV), a "translation-retranslation" process was conducted from Spanish into German and vice-versa. In addition, its content was validated for the Chilean context and subsequently evaluated by expert raters.

The therapeutic alliance variable was measured using the WAI (Working Alliance Inventory, long version) in Chile and the WAI-SR in Germany, both previously adapted for each country.

Concerning the study of cultural variables, a version of the Multidimensional Questionnaire of Cultural Variables had already been adapted for Chile based on the German version of the Multidimensional Battery of Cultural Variables (HKFB).

The MINI interview was used to identify the presence or absence of major depression in Chile. This instrument, which has been widely adopted in primary health care and in mental health clinics in Chile, is part of the diagnostic procedure at Psicomédica. In Germany, the PHQ-D is routinely used. At Heidelberg Depression Hospital, it is applied to look into the patient's depressive symptomatology.

Data analysis

The data were analyzed with SPSS 20. First, a descriptive analysis was conducted of all the variables considered in the study (the specific cultural variables *independent and interdependent self-construal, tightness/looseness of social-familial norms, traditional/egalitarian sex role ideology, expectations, quality of the early therapeutic alliance, and level of depression*) in each country. The mean, typical deviation, and typical mean error of the variables included in the study were estimated. The data of the variables for each country (Chile and Germany) were compared using Student's t-test for two independent samples, assuming that the data followed a normal distribution and that there was homoscedasticity between the data of a single variable (Díaz, 2009). The association between the dependent and interdependent variables was checked using the bivariate linear regression test. The level of significance used was $\alpha \leq 0.05$ in all cases. The comparison of the early

alliance in sessions 1 and 3 in each country was conducted using Student's t-test, after comparing homoscedasticity using Fisher's F-test (Díaz, 2009). The level of significance used was $\alpha \leq 0.05$ in all cases.

In order to compare alliances 1 and 3 in the two countries, their scores according to the WAI (Working Alliance Inventory) in its Chilean and German versions were standardized (Z scores); afterwards, a comparative analysis was carried out between the countries using Student's t-test.

Table 4. Statistical techniques used to test the study hypotheses

HYPOTHESES	**ANALYSIS TECHNIQUES**
ASSOCIATION BETWEEN EXPECTATIONS AND CULTURAL VARIABLES	
H 1. Patients with a more independent self-construal will display higher expectations in comparison with those whose self-construal is more interdependent. H1.1 Patients with a more egalitarian sex role ideology will have higher expectations than those with a more traditional ideology.	Bivariate linear regression test
RELATIONSHIP BETWEEN EXPECTATIONS AND DEPRESSION LEVEL	**ANALYSIS TECHNIQUES**
H 3 Patients with a more severe level of depression will have higher expectations regarding the treatment than those with a mild or moderate level of depression.	Bivariate linear regression test .
RELATIONSHIP BETWEEN DEPRESSION LEVEL AND ALLIANCE	**ANALYSIS TECHNIQUES**
H 4 Patients with severe depression will establish a low-quality therapeutic alliance.	Bivariate linear regression test

H 4.1 Patients with mild or moderate depression will establish a better therapeutic alliance.	
RELATIONSHIP BETWEEN EXPECTATIONS AND ALLIANCE	**ANALYSIS TECHNIQUES**
H 2 Patients with high expectations will establish a better therapeutic alliance than those with low expectations.	Bivariate linear regression test
CULTURAL VARIABLES AND ALLIANCE	**ANALYSIS TECHNIQUES**
H 5 Patients with an interdependent self-construal will establish a better alliance than those with an independent self-construal. H 5.1 Patients with a tight perception of social and familial norms will establish a better therapeutic alliance than those with a looser perception of social and familial norms. H 5.1.2 Patients with an egalitarian sex role ideology will establish a better therapeutic alliance than those with a more traditional ideology.	Bivariate linear regression test
CULTURAL VARIABLES AND DEPRESSION LEVEL	**ANALYSIS TECHNIQUES**
H 6 Patients with severe depression will perceive familial and social norms to be tighter than those with mild depression. H 6.1 Patients with mild depression will display a more interdependent self-construal than those with moderate or severe depression. H 6.1.2 Patients with severe depression will display a more traditional sex role ideology.	Bivariate linear regression test

Results

Descriptive analysis of the study variables

Table 5 shows the results of the estimation of the descriptive statistical values for each of the variables studied in Chile and Germany. Concerning patient expectations, the mean value for the Chilean sample (m= 9.46, PATHEV score) revealed them to be high. The same was true of the German sample (m= 9.80, PATHEV score) in this variable, with an SD of 1.601 and 1.669, respectively.

With respect to depression, the mean values for the Chilean sample (m= 28.4, BDI score) and the German sample (m= 25.30, BDI score) revealed moderate levels, with SD = 8.327 and 1.228 respectively.

The Chilean sample scored high for independent self-construal (m= 78.54, SCS subscale score), while the German one displayed a tendency towards independent self-construal (m= 66.57, SCS subscale score), with SD=13.378 and 7.785 respectively.

The mean of the Chilean sample indicated a highly interdependent self-construal (m= 77.59, SCS subscale score), while that of the German sample also revealed a highly interdependent self-construal (m= 59.93, SCS subscale score), with SD= 12.261 and 12.44 respectively.

With respect to social norms, the mean of the Chilean sample revealed a great degree of tightness (m=22.59, TLS subscale score). For this same variable, the mean of the German sample also revealed tightness (m=25.50, TLS subscale score), with SD= 4.660 and 3.49 respectively.

With respect to familial norms, the average of the Chilean sample indicated high perceived tightness (m=24.28, TLS subscale score), with SD= 5.222. For the same variable, the German mean revealed high perceived tightness in familial norms (m=23.27, TLS subscale score), with SD= 4.185.

Concerning the *sex role ideology* variable, the mean of the Chilean sample indicated an egalitarian ideology (m= 47.74, SRI subscale score), with SD= 11.228. The mean of the German sample for this variable also revealed a more egalitarian ideology (m=54.37, SRI subscale score), with SD= 7.924.

With respect to the early alliance, the mean of the Chilean sample reflected high quality in sessions 1 and 3 (m= 65.48 and 66.87, WAI Chilean version), with SD= 13.543 and 15.126, respectively. The mean of the German sample also revealed a high-quality therapeutic alliance in sessions 1 and 3 (m= 36.37 and 39.03, WAI-SR German version), with SD= 9.669 and 9.227, respectively.

95.7% of the Chilean sample suffered from major depression according to the MINI, while 50% of the German participants were affected by the disorder according to the PHQ-D.

Table 5. Descriptive analyses of the study variables in both countries

Independent Self-Construal	**CHILE**	**GERMANY**
N	46	30
Mean	78.54	66.57
Standard deviation	13.378	7.785
Interdependent Self-Construal	**CHILE**	**GERMANY**
N	46	30
Mean	77.59	59.93
Standard deviation	12.261	12.44
Social Norms	**CHILE**	**GERMANY**
N	46	30
Mean	22.59	25.50
Standard deviation	4.991	3.491
Sex Role Ideology	**CHILE**	**GERMANY**
N	46	30
Mean	47.74	54.37
Standard deviation	11.228	7.924
Familial Norms	**CHILE**	**GERMANY**
N	46	30
Mean	24.28	23.27
Standard deviation	5.222	4.185
Expectations	**CHILE**	**GERMANY**
N	46	30
Mean	9.46	9.8
Standard deviation	1.601	1.669
Level of depression	**CHILE**	**GERMANY**
N	46	30
Mean	28.24	25.3
Standard deviation	8.327	10.72
Major depression	**CHILE**	**GERMANY**
N	46	30
Presence	95.70%	50%

Absence	4.3	50%
Alliance 1	**CHILE**	**GERMANY**
N	46	30
Mean	65.48	36.37
Standard deviation	13.543	9.669
Alliance 3	**CHILE**	**GERMANY**
N	46	30
Mean	66.87	39.03
Standard deviation	15.126	9.227

Comparison of the study variables in both countries

Table 6 presents the results of the comparison of the variables studied in both countries. It can be observed that the differences between the countries regarding the variables *independent and interdependent self-construal, social norms, sex role ideology, and alliance 1 and 3* according to Z scores were significant ($p<0.05$). Specifically, the *social norms* variable was higher in Germany than in Chile, the *independent and interdependent self-construals* were higher in Chile than in Germany, and the egalitarian sex role ideology was more predominant in Germany.

Alliances 1 and 3, according to the WAI in its two versions, were standardized (Z scores) both in Chile and Germany; afterwards, a comparative analysis between the two countries was conducted using Student's t-test. Alliances 1 and 3, according to Chile Z scores, presented a mean (m= .613 and .580) and a SD= .722 and .799. In Germany, alliances 1 and 3 in terms of Z scores, showed a mean (m= -.939 -.890) and a SD= .515 and .487, respectively.

Significant differences were observed between alliances 1 and 3 in the two countries according to Z scores and Student's t-test, with Chile displaying a stronger tendency towards high quality than Germany.

Table 6. Results of the comparison of the study variables in both countries

	CHILE	GERMANY	t student	Sig.
Independent Self Construal				
N	46	30	4.432	.000
Mean	78.54	66.57		
Standard deviation	13.378	7.785		
Interdependent Self Construal				
N	46	30	6.1	.000
Mean	77.59	59.93		
Standard deviation	12.261	12.44		
Social Norms				
N	46	30	-2.781	.007
Mean	22.59	25.50		
Standard deviation	4.991	3.491		
Sex Role Ideology				
N	46	30	-2.806	.006
Mean	47.74	54.37		
Standard deviation	11.228	7.924		
Familial Norms				
N	46	30	.894	.374
Mean	24.28	23.27		
Standard deviation	5.222	4.185		
Alliance 1				
N	46	30	10.923	.000
Mean	.613	-.939		
Standard deviation	.722	.515		
Alliance 3				
N	46	30	9.960	.000
Mean	.580	-.890		
Standard deviation	.515	.487		
Expectations				
N	46	30	-.899	.372
Mean	9.46	9.80		
Standard deviation	1.601	1.669		
Level of depression				
N	46	30	1.341	.184
Mean	28.24	25.30		
Standard deviation	8.327	10,72		

Association between cultural variables and expectations in Chile and Germany

The association between expectations and cultural variables was found to be non-significant both in Chile and Germany ($p>0.05$) (Tables 7 and 8, respectively).

Table 7. Results of the association between cultural variables and expectations in Chile

	r	Sig.
Independent self construal	.060	.694
Interdependent self construal	.089	.579
Social norms	.204	.217
Familial norms	.041	.800
Sex Role Ideology	-.117	.451

a. Dependent variable: Expectancies

Table 8. Results of the association between cultural variables and expectations in Germany

	r	Sig.
Independent self construal	.290	.205
Interdependent self construal	.281	.167
Social norms	.140	.549
Family norms	.129	.573
Sex Role Ideology	.191	.404

a. Dependent variable: Expectancies

The results of the association between patient expectations and cultural variables led to the rejection of hypotheses 1 and 1.1, which state:

H 1: “Patients with a more independent self-construal will display higher expectations in comparison with those whose self-construal is more interdependent”.

H1.1: “Patients with a more egalitarian sex role ideology will have higher expectations than those with a more traditional ideology”.

Association between depression levels and expectations in Chile and Germany

No influence was revealed ($p>0.05$) by the study of the association between depression levels and patient expectations in Germany and Chile (Tables 9 and 10, respectively).

Table 9. Results of the association between depression levels and expectations in Chile

	r	Sig.
Level of depression	-.043	.775

a. Dependent variable: expectations

Table 10. Results of the association between depression levels and expectations in Germany

	r	Sig.
Level of depression	.058	.760

a. Dependent variable: Expectations

The results of the association between patient expectations and depression levels in Chile and Germany led to the rejection of hypothesis 3, which states:

H 3: “Patients with a more severe level of depression will have higher expectations regarding the treatment than those with a mild or moderate level of depression”.

Association between depression levels and the early therapeutic alliance in Chile and Germany

Tables 11, 12, 13, and 14 present the results of the association between the variable *alliances 1 and 3* and *depression* in Chile and Germany, respectively. No significant association was found in any of these cases ($p>0.05$).

Table 11. Results of the association between depression levels and alliance 1 in Chile

	r	Sig.
Level of depression	-.140	.790

a. Dependent variable: Alliance 1

Table 12. Results of the association between depression levels and alliance 3 in Chile

	r	Sig.
Level of depression	-.068	.655

a. Dependent variable: Alliance 3

Table 13. Results of the association between depression levels and alliance 1 in Germany

	r	Sig.
Level of depression	-.190	.314

a. Dependent variable: Alliance 1

Table 14. Results of the association between depression levels and alliance 3 in Germany

	r	Sig.
Level of depression	.074	.698

a. Dependent variable: Alliance 3

These results made it impossible to accept hypotheses 4 and 4.1, which state the following with respect to the association between the alliance and depression:

H 4: “Patients with severe depression will establish a low-quality therapeutic alliance”.

H 4.1: “Patients with mild or moderate depression will establish a better therapeutic alliance”.

Association between expectations and the early therapeutic alliance in Chile

In Chile, the expectations variable was positively associated with alliance 1: the higher the patient's expectations, the better the alliance in the first session (Table 15) ($p<0.05$), with an adjusted R2 of 0.1225 (12, 25%). No association was observed with alliance 3 ($p>0.05$) (Table 16).

Table 15. Results of the association between expectations and alliance 1 in Chile

	r	Sig.
Expectancies	.350	.017

a. Dependent variable: Alliance 1. $R^2=0.1225$; adjusted $R^2=0.107$

Table 16. Results of the association between expectations and alliance 3 in Chile

	r	Sig.
Expectations	.258	.082

a. Dependent variable: Alliance 3

Association between expectations and the early therapeutic alliance in Germany

Tables 17 and 18 present the results of the association between expectations and alliances 1 and 3 in Germany. They reveal a significant association ($p<0.01$) in alliances 1 and 3 ($p<0.05$) with expectations. The results display a positive association between these variables: the higher the patient's expectations, the higher the quality of alliances 1 and 3. The adjusted R2 value reached 0.242 (24, 2%) for the alliance 1, and R2 value reached 0.122 (12.2%) for the alliance 3.

Table 17. Results of the association between expectations and alliance 1 in Germany

	r	Sig.
Expectations	.492	.006

a. Dependent variable: Alliance 1. R^2= 0.242; adjusted R^2=0.217

Table 18. Results of the association between expectations and alliance 3 in Germany

	r	Sig.
Expectancies	.350	.017

a. Dependent variable: Alliance 3. R^2= 0.122; adjusted R^2=0.101

These results of the association between expectations and the alliance both in Chile and in Germany make it possible to accept hypothesis 2, which states:

H 2: "Patients with high expectations will establish a better therapeutic alliance than those with low expectations".

Association between cultural variables and the early therapeutic alliance in Chile

In Chile, an association was found between the cultural variable *independent self-construal* and *alliance 1* ($p<0.05$): more independence results in a better session 1 alliance (Table 19), controlling by the others variables in the model. No association was observed with alliance 3 ($p>0.05$) (Table 20).

Table 19. Results of the association between cultural variables and alliance 1 in Chile

	r	Sig.
Independent self-construal	.068	.040
Interdependent self-construal	.019	.665
Social norms	.040	.906
Familial norms	.190	.809
Sex Role Ideology	.038	.255

a. Dependent variable: Alliance 1

Table 20. Results of the association between cultural variables and alliance 3 in Chile

	r	Sig.
Independent self-construal	.148	.343
Interdependent self-construal	.023	.885
Social norms	.182	.278
Familial norms	-.079	.633
Sex Role Ideology	-.062	.694

a. Dependent variable: Alliance 3

For the Chilean sample, the results led to the rejection of hypotheses 5, 5.1, and 5.1.2, which state:

H 5: “Patients with an interdependent self-construal will establish a better alliance than those with an independent self-construal”.

H 5.1: “Patients with a tight perception of social and familial norms will establish a better therapeutic alliance than those with a looser perception of social and familial norms”.

H 5.1.2: “Patients with an egalitarian sex role ideology will establish a better therapeutic alliance than those with a more traditional ideology”.

Association between cultural variables and the early therapeutic alliance in Germany

Table 21 shows the results of the association between cultural variables (self-construal, sex role ideology, and tightness-looseness of social and familial norms) and alliance 1 in Germany. The variables *interdependent self-construal* and *egalitarian sex role ideology* were found to be associated with the alliance ($p<0.05$). This indicates that high interdependence is linked with high-quality alliance 1, and egalitarian sex role ideology is linked with high-quality alliance 1. The adjusted R2 value reached 0.136, which means that interdependent self-construal and egalitarian sex role ideology account for 13.6% of the variability observed in alliance 1.

Table 21. Results of the association between cultural variables and alliance 1 in Germany

	r	Sig.
Interdependent self-construal	.489	.005
Sex role ideology	.554	.002

a. Dependent variable: Alliance 1. $R^2= 0.136$; adjusted $R^2=0.120$

As Table 22 indicates, there is no association between cultural variables and alliance in the third session ($p>0.05$) in Germany.

Table 22. Results of the association between cultural variables and alliance 3 in Germany

	r	Sig.
Independent self-construal	-.085	.718
Interdependent self-construal	.211	.316
Social norms	-.316	.201
Familial norms	.176	.464
Sex Role Ideology	.350	.150

a. Dependent variable: Alliance 3

In conclusion, the above results regarding the association of cultural variables with alliance in Germany made it possible to accept hypotheses 5 and 5.1.2, specifically for the therapeutic alliance measured in session 1:

H 5: "Patients with an interdependent self-construal will establish a better alliance than those with an independent self-construal".

H 5.1.2: "Patients with an egalitarian sex role ideology will establish a better therapeutic alliance than those with a more traditional ideology".

Association between depression levels and cultural variables in Chile and Germany

Lastly, the results revealed that the association between depression levels and cultural variables (self-construal, sex role ideology, and tightness-looseness of social and familial norms) in Chile and Germany (Tables 23 and 24) was non-significant ($p>0.05$); therefore, it can be stated that there is no association between the specific cultural variables measured and depression.

Table 23. Results of the association between depression levels and cultural variables in Chile

	r	Sig.
Independent self-construal	-.016	.916
Interdependent self-construal	-.083	.608
Social norms	.087	.601
Familial norms	.120	.463
Sex Role Ideology	-.228	.148

a. Dependent variable: Level of depression

Tabla 24. Results of the association between depression levels and cultural variables in Germany

	r	Sig.
Independent self-construal	.279	.916
Interdependent self-construal	.039	.608
Social norms	.090	.601
Familial norms	.203	.463
Sex Role Ideology	.201	.148

a. Dependent variable: Level of depression

The above results about the association between depression levels and cultural variables prompted the rejection of hypotheses 6, 6.1, and 6.1.2, which state:

H 6: "Patients with severe depression will perceive familial and social norms to be tighter than those with mild depression".

H 6.1: "Patients with mild depression will display a more interdependent self-construal than those with moderate or severe depression".

H 6.1.2: "Patients with severe depression will display a more traditional sex role ideology".

Comparison between alliances 1 and 3 in each country

The comparison of the alliance in session 1 and session 3 for Chilean participants (Tables 25 and 26) revealed no significant differences ($p>0.05$).

Table 25. Results of the comparison between alliances 1 and 3 in Chile

	N	Mean
Alliance 1	46	65.48
Alliance 3	46	66.87

Table 26. Results of the comparison between alliances 1 and 3 in Chile

t-test for equality of means		
T	**df**	**Sig.**
-465	90	.643

Tables 27 and 28 present the results of the comparison between alliances 1 and 3 in Germany. No significant differences were discovered ($p>0.05$).

Table 27. Results of the comparison between alliances 1 and 3 in Germany

	N	**Mean**
Alliance 1	30	36.37
Alliance 3	30	39.03

Table 28. Results of the comparison between alliances 1 and 3 in Germany

t-test for equality of means		
T	**df**	**Sig.**
-1.093	58	.27

Discussion and Conclusions

Descriptive analyses

For the most part, the Chilean and German samples displayed high expectations.

Regarding depression levels according to the BDI-I, both countries displayed a moderate level of depression.

With respect to the presence or absence of major depression in the Chilean sample, according to the structured diagnostic interview, 95.7% suffered from the disorder, while 4.3% did not. In contrast, 50% of the German sample did not present major depression, while the other half did. It must be stressed that this variable was measured with two different clinical interviews in each country: the MINI in Chile and the PHQ-D in Germany.

Both Chile and Germany scored high for independent and interdependent self-construal.

It must be pointed out that, even though Chile, in the past, had been classed as a collectivist country, Chilean patients in this study displayed a high independent and interdependent self-construal, with higher scores for the former, which indicates a trend towards a more individualistic culture (Hofstede, 1980). In accordance to this, epidemiological data mention that Chile is a country that has developed rapidly towards greater individualism revealed an increased depression between 2003 and 2010, (MINSAL, 2011).

The results of the present study, which revealed high scores for independent and interdependent self-construal in the Chilean sample, match those of a study conducted by Olhaberry et al. (2011) which looked into these variables in the general Chilean population. It concluded that high scores in these two dimensions could have been the result of economic growth, political changes, new values, and greater female participation in the Chilean job market, along with a trend towards an individualistic culture in the country.

These findings are consistent with those of studies that have compared Chile and Norway, whose results indicate that the Chilean and Norwegian cultures, previously classed as

more independent, scored significantly higher in the independent and interdependent self-construal (Kolstad & Horpestad, 2009).

Their results about these variables for the German clinical sample (independent and interdependent self-construal) do not match the findings of Freund, Zimmermann, Pfeiffer, Conradi, Hunger, Riedel, Boysen, Schwinn, Rost, Cierpka, & Kämmerer (2010), who studied these cultural variables in Germany and observed a tendency towards independence. In the present study, the German sample scored high for both dimensions, with higher scores for independence.

Both Chilean and German participants perceived a high degree of tightness in social norms; however, Chile exhibited a stronger tendency towards tightness than Germany. This finding is not consistent with the results described by Olhaberry, et al. (2011) regarding this variable. In Olhaberry's study, Chile displayed a tendency towards looseness in social norms.

In contrast, the results of the German sample concerning this variable do match the findings of Freund et al. (2010), in which the German sample perceived tightness in social norms.

With respect to familal norms, tightness predominated in both countries; which matches the studies on specific cultural variables conducted in both countries (Freund et al. 2010; Olhaberry et al. 2011).

Regarding the *sex role ideology* variable, both countries displayed an egalitarian ideology. These results are consistent with the study of these variables conducted in Germany (Freund et al. 2010; Olhaberry et al. 2011).

Comparison of the level of depression between countries:

Methodologically groups are equivalent and comparable in level of depression, as there were no significant differences between levels of depression in both countries (t=1,341, p=>0 .005).

According to the MINI diagnostic interview Chile tended to have more major depression (95.7%), while this condition affected 50% of the German sample according to the

PHQ-D. The differences in the percentage of the major depression in both countries it could be because was measured with different instruments.

Another possible explanation about the differences in the highest percentage of the major depression in Chile in comparison to Germany, is that in societies that are genetically more sensitive to the social environment, collectivism can protect people from depression (Lyuten & Blatt, 2013), but when these societies exhibit a process of individuation this damping effect is weakened as the case of Chile.

Collectivist societies as Chile used to be, in recent years, are in the shift toward individualism, maybe is because of that, shows high depression rates in major depression in accordande to the MINI. There is a relation between the lack of community life, and socio cultural factors as urbanizations with high levels of depression (Campbell & Murra, 2004).

About the percentage (50%) of major depression in Germany, one might think that patients who are hospitalized are more seriously depressed than ambulatory patients, and that they are not comparable. However I think the fact that German patients are hospitalized does not necessarily indicate reflect the severity of the illness. Economic or socio cultural factors for example may influence the percentage of depressed patient who are hospitalized. In addition the hospitalization of german patients, has more to do with their health system than with the severity of their symptoms (Parcet, 2011).

It should be noted I used the BDI as inclusion criterion to determine the level of depression at the start of treatment.

Association between cultural variables and expectations in Chile and Germany

No significant association was found between expectations and cultural variables in Chile or in Germany. However according to literature, it is also important to highlight, in the context of the present study, that the culture influences the patient's expectations (Krause, 2005).

Before the patient starts his treatment, will have expectations which are influenced by their knowledge of the psychotherapeutic treatment received by neighbors or friends or their own prior experience with psychological therapy (Schulte, 2008).

Culture is a more complex phenomenon than the sum of the three specific variables measured. There are many other things that are part of culture: beliefs, representations of illness, health practices; there are other cultural variables which could be explored in future research (Marsella & Yamada, 2007). For example in relation to this, Seligman (1995) noted in his article about the effectiveness of psychotherapy, that patients benefited substantially from psychotherapy. This indicates that psychotherapy has had a positive impact on society for years. The effectiveness of psychotherapy has been empirically validated and this may influence patient's expectations before treatment.

Association between expectations and depression levels in Chile and Germany

About the association between the expectations and the levels of depression, no significant association was found between expectations and depression levels in Chile or in Germany.

A study conducted by (Schulte, 2008), showed that, at the start of therapy, depressive patients tend to have negative expectations before starts treatment, and that they were more pessimistic, were more critical of the treatment's suitability, had less hope of improvement, and displayed more fear of change.

This can have a link with Beck's theory mention: Depressive patients tend to see reality in a negative way, which may influence patient's expectations before starting treatment (Beck, 2008).

Although there was no association between these two variables in this study, and also found that most patients displayed high expectations, it's relevant to note that according to several studies depressed patients tend to have negative expectations about therapy. In my study, despite been depressed, patients mostly presented high expectations, which could be due to the greater acceptance of psychotherapy in society, nowadays (Seligman, 1995).

The empirical evidence prompts the question: Do depressed patients tend to have low expectations before starting their psychotherapeutic treatment?

Considering the contrast between the findings cited above and the present study, future research should explore the use of a sample of depressive and non-depressive patients to verify

whether Chilean depressive patients actually display lower expectations than those unaffected by this disorder.

Association between the early alliance and depression levels in Chile and Germany

The results of the present study concerning the non-association between the alliance and depression contradict other research which has connected these variables in a number of diagnoses, including depression in different populations (Castonguay, Constantino, & Holtforth, 2006). Likewise, the literature also includes examples of studies about the influence of alliance quality on the remission of depressive symptoms (Barber, Conolly, Crits Christoph, Gladys, & Siqueland, 2000, DeRubeis & Feeley, 1990).

Another study connecting the early therapeutic alliance with changes in depressive symptoms concluded that high-quality early therapeutic alliance is associated with a lessening of depressive symptoms, and that it can be said to predict the outcome of a number of types of chronic depression treatments (Arnow, Steidtmann, Klein, Rothbaum, Fisher, Constantino, Markowitz, Thase & Kocsis, 2013).

Another study, conducted by Webb, DeRubeis, Hollon, Dimidjian, Amsterdam & Shelton (2012), measured the therapeutic alliance with the Working Alliance Inventory (WAI) and depression levels with the Beck Depression Inventory (BDI) to asses changes in the depressive symptoms of two independent samples. The study found that there is an important influence between the alliance and depressive symptoms.

The results of the present research concerning the association between depression and the therapeutic alliance contradict those of the studies quoted above, given that no association could be established between these variables.

The following questions can be derived from these findings: Could sample size have influenced the non-association between depression levels and the alliance? Do severe or moderate depression levels necessarily result in low alliance quality? Given that most of the sample displayed a moderate depression level according to the BDI, can depression be said to have a relevant influence on alliance quality? Could low variability in depression levels have led to the non-association between this variable and the early therapeutic alliance?

Association between expectations and the early therapeutic alliance in Chile and Germany

In Germany, a positive association was found between expectations and alliances 1 and 3; in other words, high expectations result in high alliance quality in sessions 1 and 3.

In Chile, expectations and alliance 1 were found to be positively associated: high expectations lead to high alliance quality in the first session.

Even though Chile showed a tendency towards high-quality early alliance according to the standardization of Z scores between both scales and the comparative analysis of these variables in both countries, no association could be established between expectations and alliance 3. That is, the association between expectations and the alliance did not persist over time. A possible explanation for this phenomenon is that the Chilean participants were outpatients, while the German ones were hospitalized; alternatively, the weaker tendency towards independence observed in the German sample may also account for it. In addition, no other variables were measured which could have influenced this association. Neither confounding variables which include the therapeutic approach of the treatment, the therapists' sex, and whether the patients were receiving medication—nor contextual variables were considered in this research (Taucher, 1997).

The results of the present study with respect to the association between expectations and the therapeutic alliance match the available empirical evidence, which indicates a correlation between positive expectations and a good alliance (Castonguay, Constantino, & Holtforth Grosse, 2006; Hatcher & Barends, 1996; Horvath, Del Re, Flückiger, & Symonds, 2011; Gaston, Marmar, Gallagher & Thompson, 1989).

It should be pointed out that other studies have observed that positive expectations predicted higher alliance quality and that, for its part, the alliance mediated the relationship between positive expectations prior to the therapy and therapeutic outcome (Meyer, 2002).

In conclusion the main hypothesis of this study is confirmed: H2: Patients with high expectations will have a good quality early therapeutic alliance.

The association between expectations and alliance is an important result because it was observed in both countries in spite of cultural differences in the samples and the context of treatment. These differences can be for example, that German patients followed a psycho dynamic therapy, twice a week and were hospitalized. While Chilean sample followed a therapy with different psychotherapeutic approaches, ones a week, and were out patient.

The clinical implications are important because clinicians may be aware of the expectations before the patient begins treatment, the findings show us that they influence the early alliance especially in women with mood disorders.

In relation to this is important to remark Beutler (1983) says about expectations in psychotherapy, he said expectations is an element that can guarantee the patient's initial commitment. Thus, at the start of treatment, the therapist must be capable of creating a connection between their early interventions and the patient's initial expectations.

Association between cultural variables and the early therapeutic alliance in Chile and Germany

Chile displays a significant association between the independent self-construal cultural variable and high alliance quality of the session 1. Concerning the influence of expectations on the alliance, an association between them was only observed for A1.

In the German sample, the variables *interdependent self-construal* and the good quality of the alliance of the session 1 was found positive associated.

The fact that a tendency towards interdependence exists in the german sample, and that it is associated with high-quality alliance, is consistent with what Markus & Kitayama (1991) and Hofstede (2001) have noted: more interdependent individuals tend to desire to be connected with others, are part of several interpersonal relationships, and act following the expectations of others more than their own wishes.

Therefore, a possible explanation for this association (interdependence positive associated with alliance) in the German sample, is that more interdependent people adjust better to the elements that promote a high-quality alliance, such as a better bond with the

therapist, more adherence to therapeutic tasks, more commitment, and a better establishment of the therapeutic goals due to their tendency to work as part of a team.

In addition, it should be pointed out that Germany, despite attaining high scores for both self-construals, scored lower in both than Chile. Thus, Germany displayed a weaker tendency towards independent self-construal, which may have influenced the positive association between interdependence and A1; in contrast, no association was observed in Chile between interdependent self-construal and the therapeutic alliance.

Another possible explanation for the link between interdependence and alliance 1 in the German sample is that the participants were inpatients. This differentiated them from the Chilean participants, who were outpatients. The hospitalization of the German patients may have promoted the positive association between the cultural variable interdependent self-construal and the alliance in the first session. The permanent contact between the patients and the therapist, along with their life within the hospital context, may have generated a positive impact on the quality of the alliance established by the German patients, unlike in the case of the Chilean participants.

About this relationship, in both countries a positive association was found between self construal and alliance but in different directions, this result is difficult to interpret.

About the positive association between egalitarian sex role ideology with high-quality of the alliance 1.

A possible way to account for the positive association between egalitarian ideology and alliance 1 in Germany is that more egalitarian women tend to seek parity in all their personal and work relationships (Ruth, 1990; Pipher 1994); this, together with an interpersonal communication that privileges symmetry over complementarity (Watzlawick, 1985), can bolster high alliance quality.

For future lines of research it must be important to study in a deeper way, how self construal and egalitarian ideologies impact the evolution of the early therapeutic alliance.

It must be pointed out that both countries displayed an egalitarian ideology, but Germany scored higher than Chile in this area, which could probably have influenced its association with high alliance 1 quality.

This finding prompts the following questions:

What types of confounding variables could have influenced the positive association between independent self-construal and A1 in the Chilean sample and between interdependent self-construal and A1 in the German sample? Could the stronger tendency towards the egalitarian sex role ideology in Germany than in Chile have influenced the positive association between it and A1? Could the gender of therapist influence the sex role ideology? A female therapist connected more with patient with egalitarian sex role ideology? These issues could be explored in future research.

Limitations and future projections

This doctoral research followed the question of the possible association of expectations and alliance in two clinical samples belonging to different countries, assessing some specific cultural variables.

Its main value lies in the fact that it establishes the relation between expectations and alliance in both samples (regardless of their differences), and that it opens up relevant questions about the role cultural variables may play - in particular those related to self-construal - in the constitution of the therapeutic alliance.

A noteworthy aspect of this study is that it took into account the influence of specific cultural variables such as self-construal, sex role ideology, and the tightness-looseness of social and familial norms, exploring their connection with common psychotherapeutic factors, such as expectations and the early therapeutic alliance in depressed women through a transcultural study conducted in Chile and Germany. The results confirm some of its hypotheses, while others were found to apply only to one country and not the other, which suggests new hypotheses to be probed using more complex designs and larger samples.

Taking into account the above ideas, it is recommended increasing sample sizes and homogenizing the groups because may result in more associated variables, which may function differently in each country.

Due to its exploratory and descriptive nature, it focused on the behavior and association between the variables considered; for this reason, it can be stated that its results reveal a tendency.

In addition, it must be pointed out that other confounding variables, which were not evaluated, may have influenced the association between the variables studied. These confounding variables could be the gender of therapist, therapeutic approaches, if patient has or not medication and the context of treatment.

In the future, more exhaustive research should be conducted on one of the common factors, either expectations or the alliance, and its relationship with other cultural or contextual variables in a single country to gain a deeper understanding of this link.

It would be interesting to analyze the evolution and variations of expectations and the alliance throughout the treatment. And also future studies could look into the importance of this relationship at the beginning of the treatment.

Culture is a more complex phenomenon than the sum of the three specific variables measured. There are many other things that are part of culture: beliefs, representations of illness, health practices; that may be are related with the construction and evolutions of the therapeutic alliance which could be explored in future research.

Specifically the differences between Germany and Chile in the association of aspects of self-construal and alliance is intriguing and needs some additional explanations (for example, the samples are different not only because German participants are inpatients while Chileans are not they have more differences that could be behind the results on the cultural variables measured.

Likewise, it would be recommendable to pay close attention to cultural aspects and factors, because they may play a relevant role in the establishment of the early psychotherapeutic alliance.

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Annexed chilean version questtionaires

NÚCLEO MILENIO
INTERVENCIÓN PSICOLÓGICA
Y CAMBIO EN DEPRESIÓN

ID Participante	
Fecha	

BDI

En este cuestionario aparecen varios grupos de afirmaciones. Por favor, lea con atención cada una. A continuación, señale cuál de las afirmaciones de cada grupo describe mejor cómo se ha sentido **DURANTE ESTA ÚLTIMA SEMANA, INCLUIDO EL DIA HOY.** Rodee con un círculo el número que está a la izquierda de la afirmación que haya elegido. Si dentro de un mismo grupo, hay más de una afirmación que considere aplicable a su caso, puede marcarla también. **Asegúrese de leer todas las afirmaciones dentro de cada grupo antes de efectuar la elección.**

A	F
0. No me siento triste 1. Me siento triste 2. Me siento triste continuamente y no puedo dejar de estarlo 3. Ya no puedo soportar esta pena	0. No siento que esté siendo castigado/a 1. Me siento como si fuese a ser castigado/o 2. Siento que me están castigando o que me castigarán 3. Siento que merezco ser castigado/a
B	**G**
0. No me siento pesimista, ni creo que las cosas me vayan a salir mal 1. Me siento desanimado/a cuando pienso en el futuro 2. Creo que nunca me recuperaré de mis penas 3. Ya no espero nada bueno de la vida, esto no tiene remedio	0. No estoy decepcionado de mí mismo/a. 1. Estoy decepcionado de mí mismo/a. 2. Estoy muy descontento/a conmigo mismo/a 3. Me odio, me desprecio
C	**H**
0. No me considero fracasado/a 1. Creo que he tenido más fracasos que la mayoría de la gente 2. Cuando miro hacia atrás, sólo veo fracaso tras fracaso 3. Me siento una persona totalmente fracasada	0. No creo ser peor que otras personas 1. Me critico mucho por mis debilidades y errores 2. Continuamente me culpo de todo lo que va mal 3. Siento que tengo muchos y muy graves defectos
D	**I**
0. Las cosas me satisfacen tanto como antes 1. No disfruto de las cosas tanto como antes 2. Ya nada me llena 3. Estoy harto/a de todo	0. No tengo pensamientos de hacerme daño 1. Tengo pensamientos de hacerme daño, pero no llegaría a hacerlo 2. Siento que estaría mejor muerto/a o que mi familia estaría mejor si yo me muriera 3. Me mataría si pudiera
E	**J**
0. No me siento culpable 1. Me siento culpable en bastantes ocasiones. 2. Me siento culpable en la mayoría de las ocasiones. 3. Todo el tiempo me siento una persona mala y despreciable	0. No lloro más de lo habitual 1. Ahora lloro más de lo normal 2. Ahora lloro continuamente, no puedo evitarlo 3. Antes podía llorar, ahora no lloro aunque quisiera

K	Q
0. No estoy más irritable que normalmente 1. Me irrito o enojo con más facilidad que antes 2. Me siento irritado/a todo el tiempo 3. Ya no me irrita ni lo que antes me irritaba	0. No me canso más de lo normal 1. Me canso más fácilmente que antes 2. Cualquier cosa que hago me cansa 3. Estoy demasiado cansado/a para hacer nada
L	**R**
0. No he perdido el interés por los demás 1. Me intereso por la gente menos que antes 2. He perdido casi todo mi interés por los demás 3. Los demás no me importan en absoluto	0. Tengo el mismo apetito que siempre 1. No tengo tan buen apetito como antes 2. Ahora tengo mucho menos apetito 3. He perdido totalmente el apetito
M	**S**
0. Tomo mis decisiones como siempre 1. Estoy inseguro/a de mi mismo/a y evito tomar decisiones 2. Ya no puedo tomar decisiones sin ayuda 3. Ya no puedo tomar decisiones en absoluto	0. No he perdido peso últimamente 1. He perdido más de 2 kilos 2. He perdido más de 5 kilos 3. He perdido más de 8 kilos Estoy bajo dieta para adelgazar: SI NO
N	**T**
0. No me siento con peor aspecto que antes 1. Me preocupa que ahora parezco más viejo/a o poco atractivo/a 2. Creo que se han producido cambios permanentes en mi aspecto que me hacen parecer poco atractivo/a 3. Creo que tengo un aspecto horrible	0. No estoy más preocupado/a por mi estado de salud que lo habitual 1. Estoy preocupado/a por problemas físicos como dolores, molestias, malestar de estómago, o estreñimiento 2. Estoy preocupado/a por mi salud y me es difícil pensar en otra cosa 3. Estoy tan preocupado/a por mis problemas de salud que soy incapaz de pensar en otra cosa
O	**U**
0. Puedo trabajar tan bien como siempre 1. Tengo que hacer un esfuerzo especial para iniciar algo 2. Tengo que obligarme mucho para hacer algo 3. Soy incapaz de hacer algún trabajo	0. No he notado ningún cambio en mi atracción por el sexo 1. Estoy menos interesado/a en el sexo que antes 2. Actualmente me siento mucho menos interesado/a en el sexo 3. He perdido todo mi interés por el sexo
P	
0. Duermo tan bien como siempre 1. Me despierto más cansado/a por la mañana 2. Me estoy despertando una o dos horas más temprano de lo habitual y no puedo volver a quedarme dormido/a 3. Me despierto varias horas más temprano todas las mañanas y no logro dormir más de 5 horas	

Subtotal Página 1	
Subtotal Página 2	
Total	

CMVC*

A continuación encontrará algunas preguntas relativas a diferentes temas, como cultura, familia, valores y normas.

Al inicio de cada nueva área temática encontrará una breve instrucción para completar las respuestas. Por favor lea atentamente las preguntas y responda de manera espontánea. No existen respuestas correctas ni incorrectas. Conteste todas las preguntas.

¡Muchas gracias por su colaboración!

Antecedentes Personales

A continuación se realizarán algunas preguntas orientadas a su persona. Por favor haga una cruz en la respuesta que lo(a) represente.

Género

1 ☐ masculino 2 ☐ femenino

Edad: _____ años

Estado civil actual :

1 ☐ soltero/a
2 ☐ viviendo en pareja
3 ☐ casado/a
4 ☐ separado/a (de hecho)
5 ☐ divorciado/a (legalmente)
6 ☐ viudo/a

¿Tiene hijos?

Sí ☐ No ☐
En caso de que tenga hijos, por favor indique cuántos:_____

Nivel educacional alcanzado:

1 ☐ educación técnica completa
2 ☐ educación universitaria completa

¿Qué actividad desarrolla actualmente?
Por favor elija la alternativa que represente mejor su situación laboral
(con excepción de licencia médica y pre- y postnatal)

1 ☐ laboralmente activo (jornada completa)	06 ☐ en formación/cambio de actividad
2 ☐ laboralmente activo (media jornada)	07 ☐ servicio militar
3 ☐ laboralmente activo (ocasionalmente)	08 ☐ cesante
4 ☐ dueña de casa (sin actividad laboral)	09 ☐ jubilado/a
5 ☐ estudiante	10 ☐ otro:_____

¿Cuántas personas viven en su hogar incluido/a usted?
(no se cuentan como parte del hogar a los miembros de una comunidad)

Por favor indique cuántas:_____

¿Cuánto es el ingreso mensual líquido de la totalidad de personas que conforman su hogar?

1 ☐ menos de $ 191.000	5 ☐ entre $ 715.000 y $ 1.850.000
2 ☐ entre $ 191.000 y $ 330.000	6 ☐ más de $ 1.850.000
3 ☐ entre $ 330.000 y $ 480.000	
4 ☐ entre $ 480.000 y $ 715.000	

¿En qué país nació?

1 ☐ en Chile
2 ☐ en otro país:_____

¿En caso que no haya nacido en Chile, hace cuántos años vive en este país?

Por favor indique cuántos:_____

¿De qué país proviene su madre?

1 ☐ de Chile
2 ☐ de otro país:_____

¿De qué país proviene su padre?

1 ☐ de Chile
2 ☐ de otro país:_____

¿En qué idioma se crió?

1 ☐ castellano
2 ☐ otro idioma: _____
3 ☐ castellano y el otro idioma

¿Cuál es la nacionalidad que indica su cédula de identidad?

1 ☐ chilena
2 ☐ otra nacionalidad

*Por favor haga una cruz **SOBRE LA LÍNEA**, según su estimación personal entre las dos opciones para cada pregunta.*

Ejemplo:

Nada importante — *Muy importante*

¿Qué tan relevante es para usted su pertenencia nacional?

Nada importante — Muy importante

¿Qué tan ligado/a se siente a la cultura chilena?

Nada ligado(a) — Muy ligado(a)

¿Cuánto se ha dedicado a conocer la cultura chilena?

Nada — Mucho

TLS

Este Cuestionario se refiere a las normas o reglas sociales y familiares. Lea detenidamente cada afirmación antes de decidirse por una de las posibles respuestas. ***Marque con una cruz en alguno de los números desde el 1 al 6, de acuerdo al que mejor se ajuste a su opinión.***

1	2	3	4	5	6
Totalmente en desacuerdo	**Moderadamente en desacuerdo**	**Levemente en desacuerdo**	**Levemente de acuerdo**	**Moderadamente de acuerdo**	**Totalmente de acuerdo**

1.	En Chile hay muchas reglas sociales que cumplir.	1	2	3	4	5	6
2.	En Chile es muy claro lo que se espera de cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
3.	La gente en Chile está de acuerdo en qué es comportarse correctamente y qué no, en la mayoría de las situaciones.	1	2	3	4	5	6
4.	Las personas en Chile tienen amplia libertad para decidir cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
5.	Cuando en Chile alguien se comporta de manera inadecuada, los demás lo desaprueban fuertemente.	1	2	3	4	5	6
6.	Las personas en Chile casi siempre cumplen con las reglas sociales.	1	2	3	4	5	6

Ahora continúan las 6 afirmaciones relativas a su familia. Haga nuevamente una cruz en el número que corresponde mejor a su opinión.

7.	En mi familia hay muchas reglas que cumplir.	1	2	3	4	5	6
8.	En mi familia es muy claro lo que se espera de cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
9.	En mi familia estamos de acuerdo en que es comportarse correctamente y qué no, en la mayoría de las situaciones.	1	2	3	4	5	6
10.	Los miembros de mi familia tienen amplia libertad para decidir cómo comportarse en la mayoría de las situaciones.	1	2	3	4	5	6
11.	Cuando alguien en mi familia se comporta de manera inadecuada, los demás lo desaprueban fuertemente.	1	2	3	4	5	6
12.	En mi familia casi siempre cumplimos con las reglas.	1	2	3	4	5	6

SRIS

A continuación se presentan 9 afirmaciones sobre hombres y mujeres. Indique en qué medida está de acuerdo con estas opiniones. Para ello ***marque con una cruz en el número que más represente su opinión****.*

1	2	3	4	5	6	7
Totalmente en desacuerdo	**Moderadamente en desacuerdo**	**Levemente en desacuerdo**	**Ni acuerdo ni desacuerdo**	**Levemente de acuerdo**	**Moderadamente de acuerdo**	**Totalmente de acuerdo**

1.	El marido debería ser considerado el representante de la familia para todos los asuntos legales.	1	2	3	4	5	6	7
2.	Es igual de feo que una mujer diga garabatos que si lo hace un hombre.	1	2	3	4	5	6	7
3.	Cuando un hombre y una mujer viven juntos, es la mujer la que debería realizar las labores del hogar y el hombre las tareas físicamente exigentes.	1	2	3	4	5	6	7
4.	Una mujer debería preocuparse de su aspecto físico, porque influye en lo que las demás personas piensan de su marido.	1	2	3	4	5	6	7
5.	Las parejas homosexuales deberían ser igualmente aceptadas que otras las parejas.	1	2	3	4	5	6	7
6.	Las mujeres deberían tener permitida la misma libertad sexual que los hombres.	1	2	3	4	5	6	7
7.	El trabajo de un hombre es demasiado importante como para que se quede haciendo las labores del hogar.	1	2	3	4	5	6	7
8.	El principal deber de una mujer con niños pequeños es con su hogar y su familia.	1	2	3	4	5	6	7
9.	La mujer debería preocuparse más por apoyar el trabajo del marido, en lugar de desarrollar su propio trabajo.	1	2	3	4	5	6	7

SCS

A continuación encontrará una serie de afirmaciones, que se refieren a distintos sentimientos y formas de comportarse en diferentes situaciones. Lea cada afirmación y ***marque con una cruz en el número que mejor represente su opinión personal.***

1	2	3	4	5	6	7
Totalmente en desacuerdo	**Moderadamente en desacuerdo**	**Levemente en desacuerdo**	**Ni acuerdo ni desacuerdo**	**Levemente de acuerdo**	**Moderadamente de acuerdo**	**Totalmente de acuerdo**

1.	Me gusta ser único(a) y diferente de los demás en muchos aspectos.	1	2	3	4	5	6	7
2.	Puedo hablar abiertamente con alguien que acabo de conocer, aunque sea mucho mayor que yo.	1	2	3	4	5	6	7
3.	Aunque esté fuertemente en desacuerdo con los demás miembros del grupo, no lo digo para evitar tener una discusión.	1	2	3	4	5	6	7
4.	Respeto a las personas que ocupan un lugar de autoridad con las que me relaciono (por ejemplo un jefe).	1	2	3	4	5	6	7
5.	Yo hago lo que a mí me parece bien, sin tomar en cuenta lo que piensan los demás.	1	2	3	4	5	6	7
6.	Respeto a las personas que tienen una forma de ser sencilla y modesta.	1	2	3	4	5	6	7
7.	Yo siento que es importante ser una persona independiente.	1	2	3	4	5	6	7
8.	Yo puedo dejar de lado mis propios intereses por el beneficio del grupo en que estoy.	1	2	3	4	5	6	7
9.	Prefiero decir directamente que “no”, que arriesgarme a ser malinterpretado(a).	1	2	3	4	5	6	7
10.	Para mí es importante ser muy imaginativo(a) o creativo(a).	1	2	3	4	5	6	7
11.	Debería tomar en cuenta el consejo de mis padres al planificar mis estudios o mi trabajo.	1	2	3	4	5	6	7
12.	Mi futuro y el de las personas que están a mí alrededor están relacionados.	1	2	3	4	5	6	7
13.	Prefiero ser directo(a) y franco(a) cuando trato con personas que acabo de conocer.	1	2	3	4	5	6	7
14.	Me siento a gusto cuando colaboro con los demás.	1	2	3	4	5	6	7

1	2	3	4	5	6	7
Totalmente en desacuerdo	**Moderadamente en desacuerdo**	**Levemente en desacuerdo**	**Ni acuerdo ni desacuerdo**	**Levemente de acuerdo**	**Moderadamente de acuerdo**	**Totalmente de acuerdo**

15.	Me siento a gusto cuando soy escogido(a) para recibir felicitaciones o un premio.	1	2	3	4	5	6	7
16.	Si mi hermana o hermano fracasa, me siento responsable.	1	2	3	4	5	6	7
17.	Frecuentemente siento que mis relaciones con los demás son más importantes que mis propios logros.	1	2	3	4	5	6	7
18.	Hablar en frente de los demás en una clase o reunión no es un problema para mí.	1	2	3	4	5	6	7
19.	Yo le ofrecería mi asiento en el bus a mi profesor o a mi jefe.	1	2	3	4	5	6	7
20.	Actúo de la misma manera esté con quien esté.	1	2	3	4	5	6	7
21.	Mi felicidad depende de la felicidad de los que me rodean (para sentirme feliz necesito que los que me rodean también estén felices).	1	2	3	4	5	6	7
22.	Valoro más que cualquier cosa tener buena salud.	1	2	3	4	5	6	7
23.	Me quedaría en un grupo si me necesitaran, aunque no me sienta contento(a) dentro de él.	1	2	3	4	5	6	7
24.	Trato de hacer lo que es mejor para mí, sin tomar en cuenta cómo le podría afectar a los demás.	1	2	3	4	5	6	7
25.	Poder cuidarme bien es lo más importante para mí.	1	2	3	4	5	6	7
26.	Es importante para mí, respetar las decisiones tomadas por el grupo.	1	2	3	4	5	6	7
27.	Mantener mi propia identidad, independiente de los demás, es algo muy importante para mí.	1	2	3	4	5	6	7
28.	Es importante para mí poder mantener las buenas relacione dentro de mi grupo.	1	2	3	4	5	6	7
29.	Actúo de la misma manera en mi casa y en mi lugar de estudio o trabajo.	1	2	3	4	5	6	7
30.	Normalmente hago lo que los demás quieren hacer, aún cuando me gustaría hacer otra cosa.	1	2	3	4	5	6	7

Inventario de Alianza de Trabajo

Forma P

Instrucciones

En las siguientes páginas se plantean una serie de afirmaciones que describen algunas de las diferentes maneras en que una persona puede pensar o sentir acerca de su psicoterapeuta (psicólogo). A medida que lea las afirmaciones, cuando en el texto aparezca una _____, inserte mentalmente el nombre de su psicoterapeuta (psicólogo).

Bajo cada una de las afirmaciones hay una escala con puntaje de 1 a 7:

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

Si la afirmación describe la manera que usted piensa (o siente) siempre, marque el número 7; si esto nunca le sucede marque el número 1. Use los números existentes entremedio para describir las variaciones entre estos extremos.

Este cuestionario es CONFIDENCIAL; ni su terapeuta ni el consultorio verán sus respuestas.

Trabaje rápido; queremos conocer sus primeras impresiones.
(POR FAVOR NO OLVIDE RESPONDER *TODOS* LOS ITEMES)

Gracias por su cooperación.

I.A.T. : Adaptación a Chile (Santibáñez, 2000)

Puntajes: T: _____ M: _____ V: _____

1. Me siento incómodo (a) con _____.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

2. Creo que _____ y yo estamos de acuerdo respecto de las cosas que yo necesitaré hacer en la terapia para cambiar mi situación.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

3. Siento que me aprobleman y me tienen preocupado (a) los resultados de estas sesiones.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

4. Lo que estoy haciendo en terapia me aporta nuevas perspectivas para mirar mi problema.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

5. Pienso que _____ y yo nos entendemos.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

6. Siento que _____ percibe adecuadamente cuáles son mis metas.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

7. Encuentro confuso lo que estoy haciendo en terapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

8. Creo que _____ me estima.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

9. Desearía que _____ y yo pudiéramos clarificar el objetivo de nuestras sesiones.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

10. Estoy en desacuerdo con _____ acerca de lo que yo debería lograr en terapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

11. Creo que el tiempo que _____ y yo estamos juntos en la (s) sesión (es) no es aprovechado de modo eficiente.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

12. Me da la impresión que _____ no entiende lo que yo estoy tratando de lograr en la terapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

13.	Tengo claro cuáles son mis responsabilidades en la terapia.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
14.	Las metas de estas sesiones son importantes para mi.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
15.	Encuentro que lo que _____ y yo hacemos en terapia no se relaciona con mis problemas actuales.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
16.	Siento que las cosas que hago en la terapia me van a ayudar a lograr los cambios que deseo.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
17.	Creo que _____ está genuinamente preocupado (a) por mi bienestar.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
18.	Tengo claridad respecto a lo que _____ quiere que yo haga en estas sesiones.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
19.	Siento que _____ y yo nos respetamos mutuamente.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
20.	Siento que _____ no es completamente sincero (a) en sus sentimientos hacia mi.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
21.	Confío en la capacidad de _____ para ayudarme.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
22.	_____ y yo estamos trabajando para lograr metas terapéuticas establecidas de mutuo acuerdo.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
23.	Siento que _____ me aprecia.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
24.	Creo que _____ y yo estamos de acuerdo sobre lo que para mi es importante trabajar.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre
25.	Como resultado de estas sesiones, tengo más claro como podría cambiar.						
	1	2	3	4	5	6	7
	Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

25. Como resultado de estas sesiones, tengo más claro como podría cambiar.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

26. Creo que _____ y yo confiamos uno en el otro.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

27. Me da la impresión que _____ y yo tenemos ideas diferentes acerca de cuáles son mis problemas.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

28. Mi relación con _____ es muy importante para mi.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

29. Tengo la sensación que si yo digo o hago cosas incorrectas, _____ va a dejar de trabajar conmigo.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

30. Pienso que _____ y yo trabajamos juntos (as) en establecer metas para mi terapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

31. Estoy frustrado (a) por las cosas que estoy haciendo en terapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

32. Creo que hemos establecido un buen acuerdo sobre cuál es el tipo de cambios que serían buenos para mi.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

33. Siento que las cosas que _____ me pide que haga no tienen sentido.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

34. No sé qué resultados esperar de mi psicoterapia.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

35. Creo que la manera en que estamos trabajando con mi problema es correcta.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

36. Siento que _____ se preocupa por mi incluso cuando hago cosas que él (ella) no aprueba.

1	2	3	4	5	6	7
Nunca	Casi nunca	Ocasionalmente	A veces	Frecuentemente	Casi siempre	Siempre

PATHEV*

Instrucciones:

A continuación encontrará algunas afirmaciones acerca de las expectativas, de lo que esperan y/o temen las personas acerca de la terapia. No hay respuestas correctas o incorrectas. Nuestro interés es que conteste lo que usted piensa respecto a la psicoterapia que iniciará. Favor de marcar en el paréntesis de cada enunciado el número que mejor lo identifique en base a la siguiente escala:

	Totalmente en desacuerdo	Desacuerdo	Indiferente	De acuerdo	Totalmente de acuerdo
1. Me preocupa que aún estando en psicoterapia no se me pueda ayudar.	1	2	3	4	5
2. He encontrado la mejor terapia.	1	2	3	4	5
3. Tengo miedo de cambiar.	1	2	3	4	5
4. Creo que mis problemas por fin podrán resolverse.	1	2	3	4	5
5. Incluso participando en esta terapia mis problemas no cambiarán mucho.	1	2	3	4	5
6. Esta terapia puede ser la adecuada para resolver mis problemas.	1	2	3	4	5
7. A veces tengo miedo que la terapia me cambie más de lo que quiero.	1	2	3	4	5
8. En comparación con mis intentos anteriores, tengo la sensación de que ahora estoy haciendo lo correcto.	1	2	3	4	5
9 En realidad dudo que la terapia me pueda ayudar.	1	2	3	4	5
10 Quizás otra terapia me ayudaría mejor.	1	2	3	4	5
11. A veces me preocupo por todas las cosas que cambiaran, una vez que mis problemas hayan desaparecido.	1	2	3	4	5

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW
MINI INTERNACIONAL NEUROPSYCHIATRICA EVALUACION

MÓDULO EPISODIO DEPRESIVO MAYOR
Y
RIESGO SUICIDA

Núcleo Milenio
Intervención Psicológica y Cambio en Depresión

Versión en Español 5.0.0

DSM-IV

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Nombre:_____

Edad:_____ **Fecha:** _____

A. EPISODIO DEPRESIVO MAYOR

"▲" SIGNIFICA: IR A LAS CASILLAS DIAGNÓSTICAS, CIRCULAR NO EN CADA UNA Y NO CONTINUAR PREGUNTANDO A3 Y A4

A1	¿En las últimas dos semanas, se ha sentido deprimido o decaído la mayor parte del día, casi todos los días?	NO	SÍ	1
A2	¿En las últimas dos semanas, ha perdido el interés en la mayoría de las cosas o ha disfrutado menos de las cosas que usualmente le agradaban?	NO	SÍ	2
	¿MARCÓ **SÍ** EN **A1** O EN **A2**?	▲ NO	SÍ	

A3 **En las últimas dos semanas, cuando se sentía deprimido o sin interés en las cosas:**

a	¿Disminuyó o aumentó su apetito casi todos los días? ¿Perdió o ganó peso sin intentarlo (ej. variaciones en el último mes de ± 5% de su peso corporal ó ± 8 libras ó ± 3.5 kgr., para una persona de 160 libras/ 70 kgr.)? MARCAR **SÍ**, SI CONTESTÓ **SÍ** EN ALGUNA	NO	SÍ *	3
b	¿Tenía dificultad para dormir casi todas las noches (dificultad para quedarse dormido, se despertaba a media noche, se despertaba temprano en la mañana o dormía excesivamente)?	NO	SÍ	4
c	¿Casi todos los días, hablaba o se movía usted más lento de lo usual, o estaba inquieto o tenía dificultades para permanecer tranquilo?	NO	SÍ *	5
d	¿Casi todos los días, se sentía la mayor parte del tiempo fatigado o sin energía?	NO	SÍ	6
e	¿Casi todos los días, se sentía culpable o inútil?	NO	SÍ	7
f	¿Casi todos los días, tenía dificultad para concentrarse o tomar decisiones?	NO	SÍ	8
g	¿En varias ocasiones, deseó hacerse daño, se sintió suicida, o deseó estar muerto?	NO	SÍ	9

¿MARCÓ **SÍ** EN **5** O MAS RESPUESTAS (**A1-A3**)?

NO **SÍ ***

***EPISODIO DEPRESIVO MAYOR* ACTUAL**

SI EL PACIENTE MARCA POSITIVO PARA UN EPISODIO DEPRESIVO MAYOR ACTUAL, CONTINUE CON A4, DE LO CONTRARIO CONTINUE CON EL MODULO B:

A4 a	¿En el transcurso de su vida, tuvo otros períodos de dos o más semanas, en los que se sintió deprimido o sin interés en la mayoría de las cosas y que tuvo la mayoría de los problemas de los que acabamos de hablar?	▲ NO	SÍ	10
b	¿ Ha tenido alguna vez un período de por lo menos dos meses, sin depresión o sin la falta de interés en la mayoría de las cosas y ocurrió este período entre dos episodios depresivos?	**NO**	**SÍ**	11

EPISODIO DEPRESIVO MAYOR RECIVIDANTE

Annexes of the german version questtionaires

BDI

Dieser Fragebogen enthält 21 Gruppen von Aussagen. Bitte lesen Sie jede Gruppe sorgfältig durch. Suchen Sie dann die eine Aussage in jeder Gruppe heraus, die am besten beschreibt, wie Sie sich in dieser Woche einschließlich heute gefühlt haben und kreuzen Sie die dazugehörige Ziffer (0, 1, 2 oder 3) an. Falls mehrere Aussagen einer Gruppe gleichermaßen zutreffen, können Sie auch mehrere Ziffern markieren. Lesen Sie auf jeden Fall alle Aussagen in jeder Gruppe, bevor Sie Ihre Wahl treffen.

A
0 Ich bin nicht traurig.
1 Ich bin traurig.
2 Ich bin die ganze Zeit traurig und komme nicht davon los.
3 Ich bin so traurig oder unglücklich, dass ich es kaum noch ertrage.

B
0 Ich sehe nicht besonders mutlos in die Zukunft.
1 Ich sehe mutlos in die Zukunft.
2 Ich habe nichts, worauf ich mich freuen kann.
3 Ich habe das Gefühl, dass die Zukunft hoff- nungslos ist, und dass die Situation nicht besser werden kann.

C
0 Ich fühle mich nicht als Versager.
1 Ich habe das Gefühl, öfter versagt zu haben als der Durchschnitt.
2 Wenn ich auf mein Leben zurückblicke, sehe ich bloß eine Menge Fehlschläge.
3 Ich habe das Gefühl, als Mensch ein völliger Versager zu sein.

D
0 Ich kann die Dinge genauso genießen wie früher.
1 Ich kann die Dinge nicht mehr so genießen wie früher.
2 Ich kann aus nichts mehr eine echte Befriedi- gung ziehen.
3 Ich bin mit allem unzufrieden oder gelangweilt.

E
0 Ich habe keine Schuldgefühle.
1 Ich habe häufig Schuldgefühle.
2 Ich habe fast immer Schuldgefühle.
3 Ich habe immer Schuldgefühle.

F
0 Ich habe nicht das Gefühl, gestraft zu sein.
1 Ich habe das Gefühl, vielleicht bestraft zu werden.
2 Ich erwarte, bestraft zu werden.
3 Ich habe das Gefühl, bestraft zu sein.

G
0 Ich bin nicht von mir enttäuscht.
1 Ich bin von mir enttäuscht.
2 Ich finde mich fürchterlich.
3 Ich hasse mich.

H
0 Ich habe nicht das Gefühl, schlechter zu sein als alle anderen.
1 Ich kritisiere mich wegen meiner Fehler und Schwächen.
2 Ich mache mir die ganze Zeit Vorwürfe wegen meiner Mängel.
3 Ich gebe mir für alles die Schuld, was schiefgeht.

I
0 Ich denke nicht daran, mir etwas anzutun.
1 Ich denke manchmal an Selbstmord, aber ich würde es nicht tun.
2 Ich möchte mich am liebsten umbringen.
3 Ich würde mich umbringen, wenn ich die Ge- legenheit hätte.

J
0 Ich weine nicht öfter als früher.
1 Ich weine jetzt mehr als früher.
2 Ich weine jetzt die ganze Zeit.
3 Früher konnte ich weinen, aber jetzt kann ich es nicht mehr, obwohl ich es möchte.

K

0 Ich bin nicht reizbarer als sonst.
1 Ich bin jetzt leichter verärgert oder gereizt als früher.
2 Ich fühle mich dauernd gereizt.
3 Die Dinge, die mich früher geärgert haben, berühren mich nicht mehr.

L

0 Ich habe nicht das Interesse an Menschen verloren.
1 Ich interessiere mich jetzt weniger für Menschen als früher.
2 Ich habe mein Interesse an anderen Menschen zum größten Teil verloren.
3 Ich habe mein ganzes Interesse an anderen Menschen verloren.

M

0 Ich bin so entschlussfreudig wie immer.
1 Ich schiebe Entscheidungen jetzt öfter als früher auf.
2 Es fällt mir schwerer als früher, Entscheidun- gen zu treffen.
3 Ich kann überhaupt keine Entscheidungen mehr treffen.

N

0 Ich habe nicht das Gefühl, schlechter auszusehen als früher.
1 Ich mache mir Sorgen, dass ich alt oder unattraktiv aussehe.
2 Ich habe das Gefühl, dass Veränderungen in meinem Aussehen eintreten, die mich hässlich machen.
3 Ich finde mich hässlich.

O

0 Ich kann so gut arbeiten wie früher.
1 Ich muss mir einen Ruck geben, bevor ich eine Tätigkeit in Angriff nehme.
2 Ich muss mich zu jeder Tätigkeit zwingen.
3 Ich bin unfähig zu arbeiten.

P

0 Ich schlafe so gut wie sonst.
1 Ich schlafe nicht mehr so gut wie früher.
2 Ich wache 1 bis 2 Stunden früher auf als sonst, und es fällt mir schwer, wieder einzuschlafen.
3 Ich wache mehrere Stunden früher auf als sonst und kann nicht mehr einschlafen.

Q

0 Ich ermüde nicht stärker als sonst.
1 Ich ermüde schneller als früher.
2 Fast alles ermüdet mich.
3 Ich bin zu müde, um etwas zu tun.

R

0 Mein Appetit ist nicht schlechter als sonst.
1 Mein Appetit ist nicht mehr so gut wie früher.
2 Mein Appetit hat sehr stark nachgelassen.
3 Ich habe überhaupt keinen Appetit mehr.

S

0 Ich habe in letzter Zeit kaum abgenommen.
1 Ich habe mehr als 2 Kilo abgenommen.
2 Ich habe mehr als 5 Kilo abgenommen.
3 Ich habe mehr als 8 Kilo abgenommen.

Ich esse absichtlich weniger, um
☐ abzunehmen: Ja
☐ Nein

T

0 Ich mache mir keine größeren Sorgen um meine Gesundheit als sonst.
1 Ich mache mir Sorgen über körperliche Probleme, wie Schmerzen, Magen- beschwerden oder Verstopfung.
2 Ich mache mir so große Sorgen über gesund- heitliche Probleme, dass es mir schwerfällt, an etwas anderes zu denken.
3 Ich mache mir so große Sorgen über gesund- heitliche Probleme, dass ich an nichts anderes mehr denken kann.

U

0 Ich habe in letzter Zeit keine Veränderung meines Interesses an Sex bemerkt.
1 Ich interessiere mich weniger für Sex als früher.
2 Ich interessiere mich jetzt viel weniger für Sex.
3 Ich habe das Interesse an Sex völlig verloren.

HKFB

Sehr geehrte Damen und Herren,

im Folgenden finden Sie einige Fragen zu verschiedenen Themen, wie Kultur, Familie, Werten und Normen.

Zu Beginn eines neuen Themengebiets finden Sie jeweils eine kurze Anleitung für das Ausfüllen. Bitte lesen Sie sich die Fragen genau durch und antworten Sie möglichst spontan. Es gibt keine richtigen oder falschen Antworten. Bitte achten Sie darauf, dass Sie alle Fragen beantworten.

Herzlichen Dank für Ihre Unterstützung!

Persönliche Angaben

Im Folgenden werden Ihnen einige Fragen zu Ihrer Person gestellt. Bitte kreuzen Sie die für Sie zutreffende Antwort an oder geben Sie genauere Informationen, falls dies nötig ist.

Geschlecht:

1 ☐ männlich 2 ☐ weiblich

Haben Sie Kinder?

☐ ja ☐ nein

Wenn ja, bitte angeben, wie viele: _____

Wie viele Personen leben in Ihrem Haushalt inklusive Ihrer eigenen Person?
(WG-Mitbewohner zählen nicht zum eigenen Haushalt)

Bitte angeben, wie viele: _____

Wie hoch ist das monatliche Nettoeinkommen aller Personen in Ihrem Haushalt insgesamt?

1 ☐ weniger als 750 Euro
2 ☐ 750 Euro – 1500 Euro
3 ☐ 1500 Euro – 2250 Euro
4 ☐ 2250 Euro – 3000 Euro
5 ☐ 3000 Euro – 4500 Euro
6 ☐ 4500 Euro – 6500 Euro
7 ☐ mehr als 6500 Euro

In welchem Land sind Sie geboren?

1 ☐ in Deutschland
2 ☐ in einem anderen Land: _____

Wenn Sie nicht in Deutschland geboren sind, seit wie vielen Jahren leben Sie hier?

Bitte angeben, wie viele: _____

Aus welchem Land kommt Ihre Mutter?

1 ☐ aus Deutschland
2 ☐ aus einem anderen Land: _____

Aus welchem Land kommt Ihr Vater?

1 ☐ aus Deutschland
2 ☐ aus einem anderen Land: _____

Mit welcher Sprache sind Sie aufgewachsen?

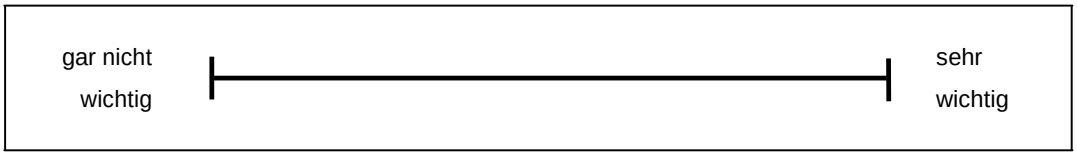
1 ☐ Deutsch
2 ☐ eine andere Sprache: _____
3 ☐ Deutsch und die andere Sprache

Welcher Nationalität gehören sie laut Ihrem Personalausweis an?

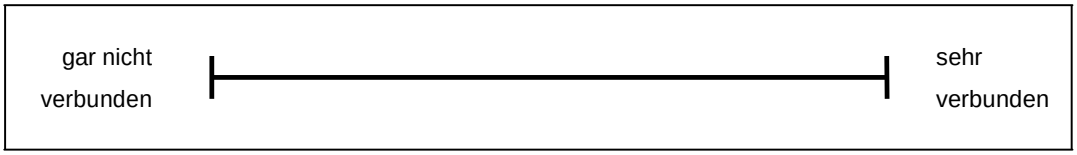
1 ☐ deutsch
2 ☐ einer anderen Nationalität: _____

Bitte machen Sie an der Stelle auf der Linie ein Kreuz, die Ihrer persönlichen Einschätzung entspricht.

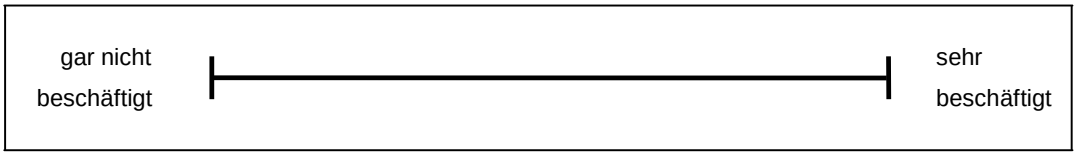
Wie wichtig ist für Sie Ihre nationale Zugehörigkeit?



Wie sehr fühlen Sie sich der deutschen Kultur verbunden?



Wie sehr haben Sie sich mit der deutschen Kultur beschäftigt?



TLS

Dieser Fragebogen enthält insgesamt 12 Aussagen mit jeweils 6 Aussagen zu Deutschland in seiner Gesamtheit und 6 Aussagen zu Ihrer Familie. Die Aussagen beziehen sich teilweise auf sog. „Soziale Normen“. Diese stellen Verhaltensregeln dar, die in der Regel ungeschrieben sind. Lesen Sie bitte die Aussagen sorgfältig durch, bevor Sie sich für eine Antwortmöglichkeit entscheiden. Ihre Antworten auf die Fragen geben Sie an, indem Sie diejenige Zahl von 1 („stimme überhaupt nicht zu“) bis 6 („stimme völlig zu“) ankreuzen, die Ihrer Einschätzung am ehesten entspricht. Dabei gibt es keine richtigen oder falschen Antworten, sondern kreuzen Sie die Antwort an, die ihre persönliche Beurteilung darstellt.

1	2	3	4	5	6
stimme überhaupt nicht zu	stimme nicht zu	stimme eher nicht zu	stimme eher zu	stimme zu	stimme völlig zu

1.	In Deutschland gibt es viele soziale Normen, die man einzuhalten hat.	1	2	3	4	5	6
2.	In Deutschland gibt es für die meisten Situationen klare Erwartungen, wie man sich verhalten sollte.	1	2	3	4	5	6
3.	In Deutschland sind sich die Menschen bei den meisten Situationen einig, welche Verhaltensweisen angemessen sind und welche nicht.	1	2	3	4	5	6
4.	Die Menschen in Deutschland haben in den meisten Situationen einen großen Spielraum für Ihr Verhalten.	1	2	3	4	5	6
5.	Wenn sich in Deutschland jemand unangemessen verhält, werden das andere sehr missbilligen.	1	2	3	4	5	6
6.	Die Menschen in Deutschland halten fast immer die sozialen Normen ein.	1	2	3	4	5	6

Nun folgen die 6 Aussagen zu Ihrer Familie. Kreuzen Sie bitte wiederum diejenige Zahl an, die Ihrer Einschätzung am ehesten entspricht.

7.	In meiner Familie gibt es viele Regeln, die man einzuhalten hat.	1	2	3	4	5	6
8.	In meiner Familie gibt es für die meisten Situationen klare Erwartungen, wie man sich verhalten sollte.	1	2	3	4	5	6
9.	In meiner Familie sind wir uns bei den meisten Situationen einig, welche Verhaltensweisen angemessen sind und welche nicht.	1	2	3	4	5	6
10.	Die Mitglieder in meiner Familie haben in den meisten Situationen einen großen Spielraum für Ihr Verhalten.	1	2	3	4	5	6
11.	Wenn sich jemand in meiner Familie unangemessen verhält, werden das die anderen sehr missbilligen.	1	2	3	4	5	6
12.	In meiner Familie halten wir uns fast immer an unsere Regeln.	1	2	3	4	5	6

SRIS

Im Folgenden werden Ihnen 9 Aussagen über Männer und Frauen vorgestellt. Bitte geben Sie an, inwiefern Sie diesen Meinungen zustimmen. Auch hier gibt es kein Richtig oder Falsch, sondern es geht um ihre persönliche Einstellung. Kreuzen Sie hierfür jeweils eine Zahl von 1 („stimme überhaupt nicht zu“) bis 7 („stimme völlig zu“) an.

1	2	3	4	5	6	7
stimme überhaupt nicht zu	stimme nicht zu	stimme eher nicht zu	unentschieden	stimme eher zu	stimme zu	stimme völlig zu

1.	Der Ehemann sollte in allen rechtlichen Angelegenheiten als Vertreter der Familie betrachtet werden.	☐	☐	☐	☐	☐	☐	☐
2.	Das Fluchen einer Frau ist nicht anstößiger als das Fluchen eines Mannes.							
3.	Wenn ein Mann und eine Frau zusammenleben, sollte die Frau den Haushalt und der Mann die körperlich schwereren Aufgaben erledigen.							
4.	Eine Frau sollte auf ihr Aussehen achten, da es beeinflusst, was andere über ihren Ehemann denken.	☐	☐	☐	☐	☐	☐	☐
5.	Homosexuelle Partnerschaften sollten gesellschaftlich genauso akzeptiert sein wie heterosexuelle Partnerschaften.							
6.	Frauen sollten die gleiche sexuelle Freiheit haben dürfen wie Männer.							
7.	Der Beruf eines Mannes ist zu wichtig, als dass er sich von Haushaltsangelegenheiten aufhalten lassen sollte.	☐	☐	☐	☐	☐	☐	☐
8.	Die oberste Pflicht einer Frau mit kleinen Kindern ist es, zu Hause bei der Familie zu sein.							
9.	Eine Frau sollte eher die Karriere ihres Mannes unterstützen als selbst Karriere zu machen.							
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐

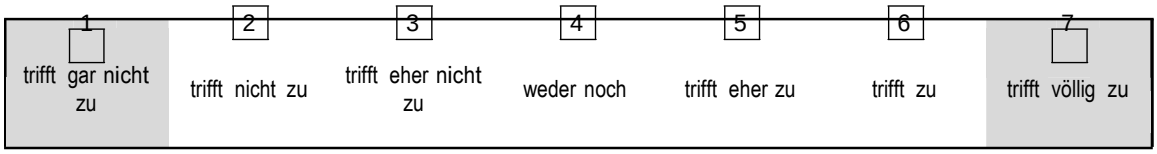
SCS

Im Folgenden finden Sie eine Reihe von Aussagen, die sich auf eine Vielzahl an Gefühlen und Verhaltensweisen in verschiedenen Situationen beziehen. Bitte lesen Sie jede Aussage durch und geben Sie an, inwieweit die Aussage für Sie persönlich zutrifft.

Sie können hierbei zwischen den folgenden Abstufungen wählen:

1	2	3	4	5	6	7
trifft gar nicht zu	trifft nicht zu	trifft eher nicht zu	weder noch	trifft eher zu	trifft zu	trifft völlig zu

1.	Es gefällt mir, einzigartig und in vielerlei Hinsicht anders als andere zu sein.	1	2	3	4	5	6	7
2.	Ich kann mit jemandem offen reden, den ich zum ersten Mal treffe, auch wenn die Person viel älter ist als ich.	1	2	3	4	5	6	7
3.	Auch wenn ich ganz anderer Meinung bin als andere Gruppenmitglieder, vermeide ich eine Auseinandersetzung.	1	2	3	4	5	6	7
4.	Ich habe Respekt vor den Autoritätspersonen, mit denen ich zu tun habe.	1	2	3	4	5	6	7
5.	Ich mache mein eigenes Ding, egal was andere darüber denken.	1	2	3	4	5	6	7
6.	Ich schätze Menschen, die bescheiden sind.	1	2	3	4	5	6	7
7.	Es ist mir wichtig, als eigenständige Person zu handeln.	☐	☐	☐	☐	☐	☐	☐
8.	Ich bin bereit, meine eigenen Interessen zugunsten der Gruppe, der ich angehöre, aufzugeben.							
9.	Ich sage lieber direkt „Nein“, als zu riskieren, dass ich missverstanden werde.							
10.	Es ist mir wichtig, eine lebhafte Phantasie zu haben.	☐	☐	☐	☐	☐	☐	☐
11.	Bei der Planung meiner Ausbildung oder Karriere sollte ich den Rat meiner Eltern berücksichtigen.							
12.	Ich habe das Gefühl, dass mein Schicksal mit dem meiner Mitmenschen verflochten ist.							
13.	Ich bevorzuge es, gegenüber Personen, die ich gerade erst kennen gelernt habe, offen und direkt zu sein.							
14.	Ich fühle mich gut, wenn ich mit anderen zusammenarbeite.							
		☐	☐	☐	☐	☐	☐	☐



15.	Ich fühle mich wohl, wenn ich durch Lob oder durch Belohnung hervorgehoben werde.	1	2	3	4	5	6	7
16.	Wenn mein Bruder oder meine Schwester versagen, fühle ich mich verantwortlich.	1	2	3	4	5	6	7
17.	Ich habe das Gefühl, dass meine Beziehungen wichtiger sind als das, was ich selber erreicht habe.	1	2	3	4	5	6	7
18.	In einer Gruppe das Wort zu ergreifen, ist kein Problem für mich.	1	2	3	4	5	6	7
19.	Ich würde meinem/ meiner Vorgesetzten im Bus meinen Sitzplatz anbieten.	1	2	3	4	5	6	7
20.	Ich verhalte mich immer auf die gleiche Weise, egal mit wem ich zusammen bin.	1	2	3	4	5	6	7
21.	Meine Zufriedenheit hängt von der Zufriedenheit der Menschen um mich herum ab.	1	2	3	4	5	6	7
22.	Ich schätze es über alles, bei guter Gesundheit zu sein.	1	2	3	4	5	6	7
23.	Ich bleibe in einer Gruppe, wenn sie mich braucht, auch wenn ich mit der Gruppe unzufrieden bin.	1	2	3	4	5	6	7
24.	Ich versuche das zu tun, was am besten für mich ist, ungeachtet dessen, wie es sich auf andere auswirken könnte.	1	2	3	4	5	6	7
25.	Eines meiner Hauptanliegen ist, für mich selbst sorgen zu können.	1	2	3	4	5	6	7
26.	Es ist mir wichtig, von der Gruppe getroffene Entscheidungen zu respektieren.	1	2	3	4	5	6	7
27.	Eine von anderen unabhängige Person zu sein, ist mir sehr wichtig.	1	2	3	4	5	6	7
28.	Es ist mir wichtig, die Harmonie innerhalb meiner Gruppe zu bewahren.	1	2	3	4	5	6	7
29.	Ich verhalte mich zu Hause auf die gleiche Weise, wie ich mich am Arbeitsplatz verhalte.	1	2	3	4	5	6	7
30.	Ich schließe mich normalerweise dem an, was andere tun wollen, auch wenn ich eigentlich lieber etwas anderes täte.	1	2	3	4	5	6	7

PATHEV

Instructions:
Here are some statements about expectations of what expect and / or fear the people about the therapy. There are no right or wrong. Our interest is to answer what you think about psychotherapy that start. Please check in the parenthesis of each statement the number that best identifies based on the following scale:

	stimmt überhaupt nicht	**stimmt eher nicht**	**stimmt zur Hälfte**	**stimmt weitgehend**	**stimmt vollkommen**
1. Ich befürchte, dass mir auch durch Psychotherapie nicht geholfen werden kann.	1	2	3	4	5
2. Ich habe die passende Therapie gefunden.	1	2	3	4	5
3. Ich habe Angst davor, mich zu verändern.	1	2	3	4	5
4. Ich glaube, dass meine Probleme jetzt endlich gelöst werden können.	1	2	3	4	5
5. Auch durch eine Therapie wird sich wohl an meinen Problemen nicht viel ändern.	1	2	3	4	5
6. Diese Therapie scheint mir für meine Probleme angemessen zu sein.	1	2	3	4	5
7. Manchmal befürchte ich, dass ich mich durch eine Therapie mehr verändere als ich will.	1	2	3	4	5
8. Im Vergleich zu dem, was ich früher versucht habe, habe ich das Gefühl, jetzt das Richtige zu tun.	1	2	3	4	5
9. Genaugenommen bin ich eher skeptisch, ob die Therapie mir helfen kann.	1	2	3	4	5
10. Vielleicht wäre mir durch eine andere Behandlung besser geholfen.	1	2	3	4	5
11. Gelegentlich mache ich mir auch etwas Sorgen, was sich alles ändern wird, wenn meine Probleme einmal verschwunden sind.	1	2	3	4	5

Working Alliance Inventory - revidierte Kurzform

Im folgenden finden Sie eine Reihe von Aussagen, die sich auf Erfahrungen beziehen, die Menschen in ihrer Therapie oder mit ihrer/ihrem Therapeut/in machen können. Bitte entscheiden Sie bei jeder Aussage, inwieweit sie auf ihre Therapie zur Zeit zutrifft. Beurteilen Sie dies auf fünf Stufen von 1 = „selten“ bis 5 = „immer“. Bitte machen Sie nur ein Kreuz pro Zeile.

	selten	**manchmal**	**öfters**	**sehr oft**	**immer**
1. Durch die Therapiestunden ist mir klarer geworden, wie ich mich verändern kann.	1	2	3	4	5
2. Was ich in der Therapie mache, eröffnet mir neue Sichtweisen auf mein Problem.	1	2	3	4	5
3. Ich glaube mein/e Therapeut/in mag mich.	1	2	3	4	5
4. Mein/e Therapeut/in und ich arbeiten gemeinsam daran, Therapieziele zu setzen.	1	2	3	4	5
5. Mein/e Therapeut/in und ich achten einander.	1	2	3	4	5
6. Mein/e Therapeut/in und ich arbeiten auf Ziele hin über die wir uns einig sind.	1	2	3	4	5
7. Ich spüre, dass mein/e Therapeut/in mich schätzt.	1	2	3	4	5
8. Mein/e Therapeut/in und ich stimmen überein, woran es für mich wichtig ist zu arbeiten.	1	2	3	4	5
9. Ich spüre, dass mein/e Therapeut/in auch dann zu mir steht, wenn ich etwas tue, was er/sie nicht gutheißt.	1	2	3	4	5
10. Ich spüre, dass das, was ich in der Therapie tue, mir helfen wird, die von mir gewünschten Veränderungen zu erreichen.	1	2	3	4	5
11. Mein/e Therapeut/in und ich sind uns im Klaren darüber, welche Veränderungen gut für mich wären.	1	2	3	4	5
12. Ich glaube, dass es richtig ist, wie wir an meinem Problem arbeiten.	1	2	3	4	5