Psychotherapy
2013, Vol. 50, No. 4, 517–524

0033-3204/13/$12.00 DOI: 10.1037/a0033361

Differential Client Perspectives on Therapy in Argentina and the United States: A Cross-Cultural Study

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Although there is a growing body of research in both cross-cultural issues in psychotherapy and in the client's perspective, little is known about differences or similarities in the way clients from different cultures, particularly those from different nations, subjectively experience therapy. The present study addressed this gap through a qualitative analysis of interviews with former therapy clients in Argentina and the United States. The researchers used a consensual qualitative research (CQR; C. E. Hill, B. J. Thompson, & E. N. Williams, 1997, A guide to conducting consensual qualitative research, The Counseling Psychologist, Vol. 25, pp. 517–572; C. E. Hill, S. Knox, B. J. Thompson, E. N. Williams, S. A. Hess, & N. Ladany, 2005, Consensual qualitative research: An update, Journal of Counseling Psychology, Vol. 52, pp. 196–205) methodology and provide illustrative examples from the raw transcripts. Among other differences, Argentine and U.S. participants differed in their experience of the therapy setting, the interventions their therapists used, and in the types of change they reported to result from therapy. Also notable, Argentine participants spoke a great deal more about change than U.S. participants. Results are preliminary, but provide implications for the adaptation of treatments to different cultures and for the cross-cultural validity of researchers' and policymakers' current definitions of treatment efficacy.

Keywords: cross-cultural, qualitative research, client perspectives

Over the past several decades, psychotherapy research has devoted increasing attention both to the importance of clients' perspectives on therapy and to cultural differences in therapeutic process and outcome. However, these topics have not enjoyed the mutual influence on one another that one might expect, and for which one would hope, given the need for culturally adapted treatments. A small number of studies on clients' perspectives have had a cross-cultural focus, and, with few exceptions, their samples were limited to a single nation. Those few studies with cross-national samples either: (a) did not sample actual psychotherapy patients and did not report qualitative data (Cherbosque 1987a, 1987b); or (b) focused their interview questions on a single aspect of therapeutic process (e.g., working alliance) and incorporated data from previous studies (Krause, Altimir, & Horvath, 2011).

A limited number of studies on ethnic minority, immigrant, and international clients' perception of therapists' cultural competency collected qualitative interview data, but all were conducted in one nation and did not disaggregate data by specific ethnicity (Chang & Berk, 2009). Studies on culturally adapted treatments and interventions have drawn from, and provided empirical support for, anecdotal knowledge about specific nations' cultural values that may be relevant to therapy. However, these too were limited to single-nation samples. The clinical utility of such studies is indubitable. However, the question remains as to how clients in different countries subjectively perceive psychotherapy differently.

Clients' Perspectives Research

In the last decade, psychotherapy researchers have argued for further investigation into what they believe has been a neglected area in the literature: the client's perspective (Fosket, 2001; Macran, Ross, Hardy, & Shapiro, 1999). This argument is justified by empirical research demonstrating the contributions of client perceptions to therapy outcome (Tallman & Bohart, 1999). Studies highlighting therapist–client disagreement on therapeutic progress (e.g., Hannan et al., 2005) provide further incentive for emphasizing the client's perspective. One study (Metcalf, Thomas, Duncan, Miller, & Hubble, 1996) found that clients and therapists disagreed on what accounts for progress in therapy, with therapists endorsing technique and clients endorsing the therapeutic relationship. This finding is especially relevant when taking into account research demonstrating a positive relationship between treatment outcome and patients' positive experience of the therapeutic relationship (Senf & Heuft, 1994). Recent meta-analyses show continued sup-

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port for the positive relationship between therapeutic alliance and outcome, with effect sizes for clients' ratings comparable with, if not slightly higher than therapists' ratings, though not significantly so (Horvath, Del Re, Flückiger, & Symonds, 2011).

Levitt and Rennie (2004) argue for the usefulness of clients' perspectives over narrative discourse from sessions after finding that clients offered material in posttherapy interviews that they did not mention to their therapists while in treatment. Much, though not all, of the research on clients' perspectives has used measures created to tap specific aspects of clients' perspectives, such as outcome expectancy (Constantino, 2012). However, several researchers (Chang & Berk, 2009; Levitt & Piazza-Bonin, 2011) now argue for the advantages of interviews over investigator-derived measures. As Levitt and Piazza-Bonin (2011) state: "An interview method allows clients more flexibility in describing their experience than one constrained by the researchers' a priori ideas about psychotherapy" (p. 71).

Although there is a large body of literature on clients' perspective on several aspects of therapy, including significant events (e.g., Elliot, 1989; Elliot & Shapiro, 1992; Levitt & Piazza-Bonin, 2011; Rhodes, Hill, Thompson, & Elliot, 1994), expectations (Marcus, Westra, Angus, & Kertes, 2011; Westra, Aviram, Barnes, & Angus, 2010), and change (Altimir et al., 2010; Binder, Holgersen, & Nielsen, 2010; Chadwick, Kaur, Swelam, Ross, & Ellett, 2011; Kuhnlein, 1999), there remains a gap in the literature in terms of how clients in different cultures perceive therapy process and outcome differently, which the present study seeks to address.

Cross-Cultural Psychotherapy Research

Cross-cultural studies on psychotherapy generally fall into one of three categories: differential outcomes research, validation studies of culturally adapted interventions, and research on therapists' multicultural competency. Although these studies provide indispensable information about cultural values and worldviews relevant to psychotherapy, there is by and large a dearth of qualitative research on clients' perspectives in this literature, particularly studies comparing interview data across nations.

Although differential outcomes research (e.g., Jones, 1982; Lambert et al., 2006; Lee & Mixson, 1995; Markowitz, Spielman, Sullivan, & Fishman, 2000; Sue, Fujino, Hu, Takeuchi, & Zane, 1991) has provided impetus for essential clinical investigations into both the adaptation of treatments for specific ethnic groups and the training of clinicians to multicultural competence, the studies are limited to quantitative data from samples within the United States. Chang and Berk (2009) argue in favor of qualitative interview data over and above quantitative data from investigator-derived self-report measures when eliciting clients' multicultural perspectives. Theirs was the second of only two qualitative multicultural competency studies. The first (Pope-Davis et al., 2002) interviewed a sample entirely made up of ethnic minorities and did not disaggregate data by specific ethnicity. Chang and Berk interviewed both U.S. ethnic minorities and Whites, but also aggregated the ethnic minority data, providing only brief illustrative examples of patients by specific ethnicity. Although these studies are a welcome supplement to the quantitative data on therapists' multicultural competence, their samples were also limited to one nation and did not examine differential perceptions of therapeutic change.

As Falicov (2009) highlights, the argument in favor of cultural adaptation of interventions (e.g., Pan, Huey, & Hernandez, 2011) appears to be winning out over the view that evidence-based treatments are universally applicable (e.g., Elliott & Mihalic, 2004). Further, evidence from a recent meta-analysis of 76 studies suggests that the more specific the adaptation the better (Griner & Smith, 2006). Such studies have drawn from qualitative data on the relationship between cultural values and therapeutic style preferences, such as Asian internationals' and Asian Americans' preference for directive, problem-solving, and self-disclosing therapists (Atkinson, Mariyuma, & Matsui, 1978; Sue & Zane, 1987; Yau, Sue, & Hayden, 1992). Although these studies provide both qualitative and quantitative data and yield valuable clinical implications, as with both the differential outcomes and multicultural competency literature, their samples were limited to a single nation. Studies with samples and researchers from multiple nations have the advantage of working with participants in their native contexts and eliminating potential cultural biases of researchers. These factors are especially important when considering the dissemination of manualized treatments to other countries, as is seen in the trend toward psychotherapy integration in Argentina (Fernandez-Alvarez, 2008; Muller, 2008; Muller & Palavezzatti, 2012). Although integration in itself may be a welcome change, treatment manuals are often translated directly, without considering cultural differences, particularly differences in subjective experience of therapy. Given the ethical concerns this poses for treatment, it is particularly important to hear clients' perspectives in their own words.

To these authors' knowledge, only two studies in the psychotherapy research literature sampled participants from multiple nations (Cherbosque, 1987a, 1987b). However, the first used only investigator-derived measures, and the second did not systematically analyze and report its interview data. Further, the participants were not psychotherapy patients, so data on their perspectives on therapy process and outcome, qualitative or otherwise, could not actually be collected.

There is an obvious lack in the cross-cultural psychotherapy research when no study exists that gathers qualitative interview data on perspectives on therapy process and outcome of clients in different countries. Comparing client perspectives across studies conducted in different countries is one possible alternative to sampling from different nations within the same study. However, this approach is problematized by a number of factors, including the vast array of qualitative methodologies in existence (Frommer, Langenbach, & Streeck, 2004), variation in interview structure and content across studies, and the difficulty in matching patient characteristics across samples. One study (Krause, Altimir, & Horvath, 2011) compared qualitative interview data from five different studies on the therapeutic alliance in Germany (Krause, 1992a, 1992b) and Chile (Altimir et al., 2010; Krause, 2005; Krause & Cornejo, 1997; Winkler, Avendaño, Krause, & Soto, 1993). Although interview format and qualitative methodology was consistent across studies, sampling from multiple nations within the same study would have both controlled for methodological differences and allowed for investigation into a broad range of therapeutic process and outcome variables, as opposed to having to pull from several studies to tap a single construct (i.e., the alliance).

Present Study

The present study compares clients' perspectives on therapy across cultures. An open-ended interview format allowed for a richer and fuller view of clients' perspectives than investigator-derived self-report measures. Sampling from two different nations and interviewing clients in their respective native contexts provided for a more naturalistic look at differential clients' perspectives. Results raise implications for the adaptation of treatments to other cultures as well as challenges to current assumptions about the universality of clients' perceptions of therapeutic change. This latter point may have further implications for researchers', clinicians', and funding institutions' current criteria for treatment efficacy. Argentina and the United States were chosen as the two cultures for comparison, owing to active psychotherapy practice and research occurring in these countries and a growing partnership between their research institutions.

Method

Sample and Recruitment Procedures

Participants were recruited from Buenos Aires and New York City through "snowball" sampling (Heckathorn, 1997). Researchers asked a group of initial contacts for referrals to individuals that met the following eligibility criteria: participants must be ≥18 years of age and not have a diagnosis of severe mental illness; participants received treatment in an outpatient setting from a psychologist or psychiatrist; participants ended treatment no more than 3 years prior to the time of their interview. Snowball sampling often entails asking the individuals in the first round of referrals for additional referrals and so on. However, the researchers deemed the sample yielded from the first round of referrals sufficient for the present study. The Argentine team approached 18 prospective participants. Seventeen accepted and 13 met all inclusion criteria. Three men and three women were then randomly selected for the final sample. The U.S. team approached 18 prospective participants and kept six based on their match with the Argentine sample's demographics.

U.S. clients. The U.S. sample ($n = 6$) self-identified as four females (66.6%) and two males (33.3%), ranging in age from 23 to 51 years old ($M = 32.7$, $SD = 10.1$), with treatment durations ranging from 3 to 120 months ($M = 25.29$, $SD = 24.57$) and time between termination and interviews ranging from 18 to 36 months ($M = 26.17$, $SD = 8.01$). Three held undergraduate degrees (50%) and three held graduate degrees (50%), one of which was a master's degree in counseling psychology.

Argentine clients. The Argentine sample ($n = 6$) self-identified as three males (50%) and three females (50%), ranging in age from 24 to 55 ($M = 36.16$, $SD = 10.53$), with treatment durations ranging from 4 to 120 months ($M = 34.17$, $SD = 44.82$) and time between termination and interviews ranging from 2 to 36 months ($M = 13.67$, $SD = 12.68$). Three held undergraduate degrees (50%), one of which was in psychology, and three held graduate degrees (50%).

U.S. therapists. According to client report, U.S. therapists ($n = 6$) were four females (66.6%) and two males (33.3%) of the following client-assessed theoretical orientations: two psychodynamic (33.3%), two cognitive–behavioral (33%), one humanistic (16.67%), and one eclectic (16.67%).

Argentine therapists. According to client report, Argentine therapists ($n = 6$) were four males (66.6%) and two females (33.3%) of the following client-assessed theoretical orientations: four psychodynamic (66.6%), one eye movement desensitization and reprocessing (EMDR; 16.67%), and one unknown (16.67%).

Procedures

A semistructured interview format was used for the study. Interviewer training involved observing an interview and conducting a mock interview under observation before interviewing study participants. The researchers developed the interview content by devising a list of themes of interest and conducting a series of mock interviews and revisions. The second, third, and sixth authors translated the final version into English. The third author served as the interviewer for the Argentine sample and the second author as the interviewer for the U.S. sample. Examples of standard interview questions include *What led you to therapy?*; *What kinds of expectations did you have?*; *How did your therapist orient you to what you would be doing in session?*; *Describe where your therapy took place*; *How would you describe your relationship with your therapist?*; *What did you specifically do in your therapy sessions? Readings? Homework?*; *Have you noticed any changes due to your therapy?*; *What aspects of therapy helped you to change?*

Interviewers and interviewees were matched according to language preference, so that all Argentine participants were interviewed by Argentine researchers and all U.S. participants were interviewed by U.S. researchers. The Argentine sample's interviews ranged from 36 min, 17 s to 79 min, 9 s in duration and were conducted at the University of Belgrano or in the participant's home or office in Buenos Aires. The U.S. sample's interviews ranged from 49 min, 29 s to 63 min, 13 s in duration and were conducted at the New School for Social Research in New York City. Interviewees gave informed consent before each interview. Interviewers gathered interviewees' demographic information through a series of questions at the beginning of the interviews. Interviews were audiotaped and transcribed in their original language by the study authors. Participants were assigned an identification number in place of their name and any other identifying information to ensure the confidentiality of their interview responses.

Analysis

A consensual qualitative research (CQR; Hill, Thompson, & Williams, 1997; Hill et al., 2005) methodology was used to analyze the interview data. At all phases of analysis, the methodology involves judges coding data independently, convening to argue to consensus on codes, and reaching consensus on final codes with a third party auditor. Judges and auditors discuss their theoretical and cultural biases before and throughout all phases.

Although Hill and colleagues (2005) recommend three coders per team, they consider two coders per team acceptable. Hill and colleagues (1997) also acknowledge the potential for modification of CQR methods and team structures. The first and second authors coded data from the U.S. sample and the third author and two other graduate-level researchers coded data from the Argentine sample. The fourth author served as the auditor for both teams. All re-

searchers involved were at least masters-level, and in most cases doctoral-level, psychology students or doctoral-level psychologists.

Coding domains. Domains were thematically coded to provide a conceptual framework for clustering data (Hill et al., 1997; 2005), also referred to as a "start list" (Miles & Huberman, 1994). An initial list of domains was made from two interviews in each sample. The lists were compared and revised to a final version. The remaining interviews were coded according to this version and no new domains appeared. The final list of domains are as follows: *Reason for Consultation*, *Mode of Therapist Selection*, *Expectation*, *Setting*, *Approach*, *Interventions*, *Patient Actions*, *Therapeutic Relationship*, *Perception of Therapist*, *Experience of Therapy*, *Significant Events*, *Change, Termination*, *Post-Therapy Contact*, and *Post-Therapy Change*.

Writing core ideas. Once interview material was clustered into domains, these clusters of patient responses were abstracted into *Core Ideas* or summaries of the responses.

Cross-analysis. In the final phase of the analysis, core ideas from all six participants in each sample were grouped into *Categories*. For each sample, the number of participants whose core ideas fit each category was tallied to provide a frequency. Unique to our study was the subsequent comparison between samples on the frequency of participants in each category. Based on an initial assessment of the core ideas in each sample, the researchers decided to focus the cross-analysis on the five domains that would yield the best balance of similarities and differences between samples: reason for consultation, mode of therapist selection, setting, interventions, and change. The same process of independent judging, consensus, and auditing was observed for this phase, as with all prior.

Results

Hill and colleagues (1997) use the terms *rare*, *variant*, *typical*, and *general* to describe the frequency of a category, according to the number of participants with responses falling into that category. In the present study, rare refers to categories for which only one patient's response fits, variant refers to categories for which two patients' responses fit, typical refers to categories for which three to four participants' responses fit, and general refers to categories for which five to six participants' responses fit. For each domain, the results are presented in these terms in the text. In Table 1, the results for the Change domain are presented as the number of participants whose responses fit each given category, rather than by Hill and colleagues' frequency terms. Owing to the small sample sizes, results should be interpreted with caution. Illustrative excerpts are provided for select categories.

Reason for Consultation

Two categories—*patient sought treatment for adjustment to a life event* and *patient sought treatment for anxiety symptoms*—were typical for both samples. In the first category, a U.S. participant reported, "At the time I started therapy . . . I had lost a neighbor that I was close to. I thought it would be beneficial to go to therapy. My neighbor . . . was like a second parent to me," whereas an Argentinian participant reported, "I've had several miscarriages. I went (to therapy) to talk about what was going to happen to me in a new pregnancy. I wanted to be able to go through it with pleasure, without being afraid." One category—*patient sought treatment for employment related issue*—emerged from the U.S. data but not the Argentinian data, though this category was variant for the U.S.

Table 1
Cross-Analysis of Categories in Change Domain

Category	Argentina	U.S.
Decrease in anxiety	3	5
Improvement in interpersonal functioning	4	4
Improvement in vocational/educational functioning	2	2
Improvement in general functioning/ability to cope	4	3
Change due to interventions	5	1
Change related to therapist's attitude	3	1
Change related to reason for consultation	6	0
Emotional change	4	0
Intrapersonal change	5	0
Attitudinal change	6	0
Behavioral change	5	0
Cognitive change	5	0
Change related to the past	4	0
Increase in insight	0	5
Improvement in self-image	0	3
Internalization of the therapist/therapeutic model	0	2

Mode of Therapist Selection

Patients typically chose their therapists from an *outside referral source* in both samples. However, one difference was that Argentinian participants were typically *referred by friends or family*, whereas U.S. participants were typically *referred by medical professionals*. Among other differences, only Argentinian participants reported *looking for a therapist with a specific theoretical orientation*. One reported, "I searched for psychoanalytic associations that were well known. Three months after arriving in Buenos Aires I went to one of them."

Setting

There was only one shared category between samples for this domain: Both Argentine and U.S. participants reported their therapists giving them *a choice of how often therapy would meet*. The remaining categories emerged only from the Argentinian sample: Argentinian participants typically reported that their *therapists took into account their financial situation* when setting the cost of treatment and gave them a *choice of whether to sit face-to-face or lie on a couch*. For the former category, one participant reported, "At the beginning, he (therapist) suggested having more than one session in a week and I told him that my budget was limited. The first year of treatment he gave me a discount." For the latter category, one participant reported, "During the third interview I told him (therapist) I wanted to lie on the couch . . . . Seven years later, after an interruption, I told him I wanted a face-to-face situation, because I had talked enough of the past . . . . He did not argue about it."

Interventions

Within this domain, two categories emerged from both samples: both U.S. and Argentinian participants reported that their thera-

pists used *supportive interventions* and *suggested reading material*. Otherwise, there was a large degree of variation between samples. An Argentine narrative that fit the latter category is as follows:

> At some point in the initial sessions he recommended a book. He asked me please to read it. It took me 3 months to start reading it. When I finally did it I was surprised, because it was exactly my situation. It was his way of showing me that this is how the world is—it wasn't just me.

A U.S. participant's narrative fitting this category is as follows:

> Sometimes she would give me readings, which I enjoyed a lot, on mindfulness research. I liked reading it and it was the same things she was doing with me. I am sure they were the basic books of CBT, but they were really helpful.

Nine categories emerged from the Argentinian data and not, or rarely, from the U.S. data: *therapist self-disclosure*, *introducing therapeutic model*, *intervening with direct questions*, *directive interventions*, *advice giving*, *offering a new perspective*, *sharing personal opinion with the patient*, *giving awareness*, and *giving feedback*. An example of a statement that fell into directive interventions is, "(My therapist) said I had to go to a general medical practitioner and get some blood tests, and I did it, because I trusted her." In a different dyad, advice giving was coded for the following narrative, "(My therapist) told me how my routine had to be 'in the morning, give yourself the injection, calmly, all alone . . . ..' She gave me practical advice." An example for the sharing personal opinion category is the statement, "One very nice thing is that (My therapist) expressed value judgments . . . it was like certain guesswork slipped out of him, but in my view it made it more human. I'll never know if he did it intentionally or spontaneously." One participant's report of an intervention that was categorized as giving awareness is, "One of the things I realized is that self-therapy is not enough . . . . The therapist's point of view was very enriching, especially because I realized that my reasoning was not always right." One participant's statement was coded both for the intervening with direct questions and giving feedback categories: "This is how every session went: I started talking, then she asked very specific questions; I continued talking and then, by the end, she expressed how she saw me, some kind of feedback."

Seven categories emerged from the U.S. data and not, or rarely, from the Argentine data: *therapist disclosed diagnosis*, *therapist provided psychopharmacological referral*, *therapist administered intake measures*, *therapist used cognitive–behavioral interventions*, *therapist taught relaxation techniques*, *therapist drew connections between the past and present*, and *therapist encouraged self-assertion*. An example of therapist encouraged self-assertion is one participant's report that, "(My therapist) told me to tell her when things were not working for me."

Change

Overall, Argentine clients spoke more about change than U.S. clients: Argentine participants made more than four times as many statements about change than U.S. participants, which were grouped into several more categories. Four categories were common to both samples: *decrease in anxiety symptoms*, *change in interpersonal functioning*, *change in vocational/educational functioning*, and *change in general functioning/ability to cope*. For decrease in anxiety symptoms, one Argentine participant reported, "(My therapist) was someone who always saw the positive side, helped me not have fears. Fear had paralyzed me," while one U.S. participant reported, "I began to have less panic attacks and feel less anxious in general." For change in interpersonal functioning, one U.S. participant reported, "My husband noticed changes in me. I started telling people what I was going through. I hadn't been honest about what I was going through before," while one Argentine participant reported:

> Therapy focused specially on my relationship with my mother and my father. The first time he mentioned bad things about my father I got really angry, but after a while there was a big relief, as I could assimilate them. I have a better relationship with my parents since then.

For change in vocational/educational functioning, one U.S. participant reported, "I became more confident at work and took on more. Before I would try to avoid certain tasks and certain things," while one Argentine participant reported, "Another change is that I could change professions, and choose the one that actually brought me joy. I could let go of the previous one without remorse." For change in general functioning/ability to cope, one U.S. participant reported, " . . . (My therapist) told me 'you're aloud to say how you feel, they don't have to agree and they don't have to like it,' and that really made a difference . . . . It stuck with me," while one Argentine participant reported, "The main change was the way I face life, the fact that there's no need for everything to be good all the time."

Nine categories emerged from the Argentine data and not at all, or rarely, from the U.S. data: *change due to interventions*, *change related to therapist's attitude*, *change related to reason for consultation*, *emotional change*, *intrapersonal change*, *attitudinal change*, *behavioral change*, *cognitive change*, and *change related to the past*. An example of change due to interventions was the following narrative by an Argentine participant:

> While talking about my father . . . (My Therapist) told me "it's as good as it gets. You need to see him as a real person and not as a superhero." Now I have a good relationship with my father. I don't blame him for anything anymore. It's become a healthier relationship.

An example of emotional change is one participant's report, "(Therapy) helped me to distance myself from my emotions; to go out of my belly button and see the world objectively." For intrapersonal change, a participant reported, "(Therapy) helped me a lot to realize that . . . things do not always have to be right . . . . Things can be right or wrong and, if they are wrong, they can sometimes be resolved and sometimes not." The final illustration of a change category for the Argentine sample was the following narrative, which was grouped into attitudinal change:

> Therapy helped me set out things in a different way and react in other ways. I could have a little more control over things . . . . It helped me realize I was mistaken in some of my actions, they were not functional for my purposes . . . . The attitude changes remain in time.

Three categories emerged from the U.S. sample and not from the Argentine sample: *increase in insight*, *improvement in self-image*, and *internalization of the therapist/therapeutic model*. For

improvement in self-image, one U.S. participant reported, "I would tell myself that it is okay that I wasn't able to do some things. I became less hard on myself and more accepting of myself during therapy." For internalization of the therapist/therapeutic model, one U.S. participant reported, ". . . therapy helped me model a way to have a constant presence for myself. It was nice to just have someone there whenever I needed it."

Discussion

The present study was designed as an exploratory qualitative investigation into cultural differences between U.S. clients and Argentine clients with regards to their perspectives on psychotherapy, as gathered from a standardized follow-up interview. The results are preliminary and are intended to generate hypotheses in several areas of research, including potential ways to adapt interventions for use in other cultures and to adapt measures of therapeutic change for different cultures. The study findings are summarized and discussed alongside both the cultural factors that may account for them as well as consistencies with previous qualitative studies on clients' perspectives.

Although there were some similarities in the interview responses of Argentine participants and U.S. participants, there were a great many, and noteworthy, differences. Such differences have important implications for the adaptability of treatments developed in one country to culturally valid practice in another country, especially given the increasing practice of cognitive and other manualized treatments. Though psychotherapy thrives in Argentina, with one clinical psychologist for every 696 people (Muller & Palavezzatti, 2012), and has its own character, Argentine researchers acknowledge the fact that, in large part, psychotherapy as we know it in Argentina is rooted in schools of thought from other countries (Fernandez-Alvarez, 2008).

One similarity between samples—anxiety as a common reason for consultation—is perhaps not surprising, given the prevalence of anxiety disorders over and above other mental disorders, as reported in reviews of epidemiological research (Kessler, Ruscio, Shear, & Wittchen, 2010). Differences in reason for consultation included U.S. participants sought treatment for employment-related issues and intimate partner problems, whereas Argentines did not, and U.S. participants were referred to treatment by health professionals, whereas Argentines were referred by friends and family. Additionally, only Argentine participants looked for a therapist with a specific theoretical orientation. These differences may be owing to the highly sanctioned status of psychotherapy in Argentina. Several researchers have commented on the commonplace nature of therapy in the culture, which is used as much for personal development as for the treatment of a serious disorder (Fernandez-Alvarez, 2008). A recent article in the New York Times featured a quote from an Argentine construction worker, flexing his knowledge of psychoanalytic theory and commenting on the shrewdness of Argentines as therapy consumers (Romero, 2012).

Argentine participants reported that their therapists were flexible with regards to certain aspects of the therapy setting, such as whether to sit in a chair or lie on the couch and the cost of treatment. U.S. participants did not express similar therapist flexibility when discussing these logistical aspects of therapy. However, relative to U.S. participants, more Argentine participants were in psychodynamic therapies, in which these issues are perhaps more salient than in other therapies. In a recent survey of 535 Argentine therapists, 53.1% identified as psychoanalytic in orientation, and of the 39.8% that identified as integrationists, 63.2% identified psychoanalysis as their base theory (Muller, 2008). Although this survey reflects the previously cited trend toward integration (Muller & Palavezzatti, 2012), it also speaks to psychoanalytic therapies' enduring presence in the country.

In the Interventions domain, Argentine and U.S. samples had roughly the same number of categories and some similarity in their content, though overall this was a broad domain with a large degree of variability. Relative to U.S. participants, Argentine participants more often described their therapists as self-disclosing and directive (giving advice, feedback, offering a new perspective, and using directive interventions). These results are consistent with other research findings on Latin American clients' therapeutic style preferences (Falicov, 2009). Compared with Argentine participants, U.S. participants described their therapists as more encouraging of self-assertion, more cognitive–behavioral in their interventions, and more focused on diagnosis, psychopharmacology, and psychological testing. The greater number of cognitive therapists in the U.S. sample might account for some of these results, given the specific cognitive interventions used and the administration of self-report measures. Similar to the consistency between the number of dynamic therapists in the Argentine sample and the prevalence of dynamic therapists in Argentina (Muller, 2008), the greater number of cognitive therapists in the U.S. sample is perhaps reflective of the greater prevalence of cognitive therapists in the United States, as shown in recent surveys by the APA (Norcross, Karpiak, & Santoro, 2005). Despite the researchers' efforts to control for modality, the samples came to reflect these cultural differences.

For the change domain, aside from some commonalities, such as the emergence of the decrease in anxiety category, Argentine participants had a great deal more responses about change, which fell into several categories that U.S. participants' much smaller number of responses about change did not. These included emotional change, intrapersonal change, attitudinal change, behavioral change, cognitive change, change related to the past, and change related to reason for consultation. There were only three uniquely U.S. categories: increase in insight, improvement in self-image, and internalization of the therapist/therapeutic model. The greater number of change statements made by Argentine participants, and categories to emerge from these statements, may be owing to the vitality of psychotherapy in Argentine culture, which may give Argentines a more extensive lexicon about psychotherapeutic change from which they can draw when asked to respond to open-ended questions about their experiences in therapy. The overarching and most important conclusion to draw from this preliminary study is that the experience of psychotherapy varies in different cultures, which demands consideration of interventions and therapeutic change in light of the culture in which treatment takes place. Further research based on these considerations is necessary.

Limitations

The current study addressed a gap in the research by investigating cross-cultural differences in clients' perspectives on therapeu-

tic change in two different countries. However, there are several limitations to the study. First, the study is exploratory in nature, and, owing to the size of each sample ($n = 6$), results are preliminary and by no means conclusive of cultural differences between the two countries. Second, there were two primary analysis teams, whose members were from the same country as the samples whose data they coded. Not only is having two different teams of coders inconsistent with CQR, but could possibly have resulted in cultural differences in coding. Third, different researchers conducted the interviews for each sample to match clients and interviewers by language preference. Although measures were taken to standardize the administration of the interview, interviewer style may have differed, eliciting different responses across samples. Other limitations include lack of demographic and background data, such as clients' diagnoses, ethnicity, and number of previous treatments, and the reliance on retrospective recall in interviews mostly conducted nearly 2 years after treatment.

Future Directions

This exploratory qualitative study on cultural differences in clients' perspectives on therapy provides impetus for further research on the subject. Future directions include increasing the sample size and further analyzing the data, including the relationship and expectations domains. Further research might also include quantitative outcome and process data to supplement and compare with the qualitative data. Lastly, participants from cultures with more distinct values and worldviews, relative to the U.S. and Argentina, need to be sampled for their perspectives on therapy and therapeutic change.

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Received April 16, 2013
Accepted April 19, 2013 ■