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The Role of Culture in Psychodynamic Psychotherapy: Parallel Process Resulting From Cultural Similarities Between Patient and Therapist

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This case illustrates how cultural issues can influence the progression of psychodynamic therapy. During the course of supervision, the resident learns how understanding the cultural similarities and differences between patient and therapist both enhances and hinders the treatment. The supervisor demonstrates the utility of parallel process during supervision in general and as a tool to uncover key cultural issues. The Grand Rounds discussion highlights cultural aspects of the case such as psychotherapy in a second language, assumptions about traditional roles, and demonstrations of closeness.

Case Presentation

“Ms. B” is a 38-year-old Ecuadorian woman in her first year of medical school who presented with the chief complaint: “I wish I could just accept and love my boyfriend.” Ms. B was receiving therapy in a psychopharmacology clinic for 1 year from a psychiatry resident when she began describing worries about conflicts with her boyfriend of 2 months. The psychopharmacology resident referred Ms. B to the psychodynamic therapy clinic for a consultation. Ms. B’s past psychiatric history is contributory for recurrent major depression, which had been in remission for 3 years since she began taking fluoxetine. She had no prior suicide attempts or hospitalizations. She reported no other symptoms of axis I pathology. The family history was notable for multiple family members being depressed and one family member attempting suicide. She reported no substance abuse and did not have any medical problems.

Dr. Carolyn Rodriguez

After establishing that the patient’s depression was well controlled, the patient’s dominant problems appeared related to romantic relationships. The patient agreed to begin twice weekly psychodynamic psychotherapy. We had a positive alliance, and I looked forward to working with her. She came with concerns about her relationship, stating, “When I think about marrying my boyfriend, it feels like death.” During the first several months of work together, I felt her self-esteem was tenuous and opted to use mostly supportive interventions.

From the start, the fact that we were both Hispanic was an issue. Although we were from different countries, in our first session, Ms. B said she feared comparing herself to me, commenting that we were “quite similar, given our Hispanic backgrounds and professional-

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minded careers.” I, too, was surprised by the similarities. We were both young professional women in training and raised in traditional Hispanic households.

During the fourth session, the feeling of “sameness” became particularly intense. Ms. B told me about a neighbor who told her that she was attractive and that his favorite song was “*Mamá me lo contó*,” (literally: “mother told me about it”). She then asked me if I spoke Spanish. When I asked what it would mean to her if I spoke Spanish, she responded: “it would probably mean we encountered the same difficulties...you probably grew up poor and were the first in your family to go to school.” Satisfied with this, I continued the session, until Ms. B called my attention to the fact that the song title had a sexual double meaning. She went on to say she did not like to speak Spanish with men because “in Spanish, things are more intimate, which makes me more nervous, and I revert to being a submissive female.” I, in turn, responded to her description of intimacy with an overwhelming and anxiety provoking countertransference fantasy that the floor was falling out from underneath us, and we were merging. Although we didn’t know it, this one episode would shape the course of the next year of therapy.

Soon after beginning treatment, Ms. B began arriving late to her appointments with me. Exploration revealed that the pace and frequency of the sessions were producing anxiety. My supervisor suggested I tell the patient that both she and I had control over the pace of sessions. Together, the patient and I determined it would help to have a 5-minute “warning” from me before the end of each session. Although I was aware that this may have had elements of a transference-countertransference enactment, Ms. B found this helpful and started coming on time again, illustrating that anxiety about merging and dependence continued to be important in the management of the treatment.

Only in retrospect did I realize that our initial perception and fear of “sameness” resulted in my setting aside her Hispanic heritage. The patient and I took refuge in the less intimate English language and American culture as a way of creating a safe “distance.” In the second year of treatment, I discovered that my presumption of sameness resulted in my neglecting her individuality. I realized that I had not asked what she meant when she made cultural references. For example, when Ms. B used the term “Catholic guilt,” I accepted it at face value. When I finally asked her to define it, she told me it was “always being watched by a forgiving but judgmental person” and then remarked, “Sometimes I think if you put a curtain up between us, you could be a priest...and you would say, ‘tell me your sins.’” It was only through giving up the assumption of similarity, with its consequent misperception of closeness, that the patient’s fears about being judged became apparent.

Another way in which a safe “distance” was created early during the second year of treatment was related to my maternity leave. When I told Ms. B the date I planned to stop seeing patients before my leave, Ms. B decided to end our sessions 1 month before this date, unlike all of my other patients. During our last session before my maternity leave, Ms. B said: “I feel like a little kid...I feel jealous of little babies that get to ask for what they want,” reflecting her feelings of helplessness and anger toward me, who she perceived as a neglectful mother who was not tending to her dependency needs.

In our first session after my maternity leave, I was surprised when Ms. B hugged me. Oscillating between whether or not to explore the meaning with the patient, I decided to not interpret it, thinking that in Hispanic culture this would be very natural: it would be very cold to not hug and congratulate someone who had just had a baby. However, as will become apparent later, this decision also revealed my ambivalence about learning about intimate feelings, both positive and negative, that my patient had for me.

Another predominant countertransferential feeling was a sense that I was not “Spanish enough” or “poor enough” for her to feel I understood her. It was not until preparing this Grand Rounds and working with my supervisor that I realized this. During one supervisory session, an interesting parallel process emerged. My supervisor noted that she herself was carefully enunciating Spanish words and rolling her r’s, to show me she was “Spanish enough.” Immediately after my supervisor commented on this, I realized I was trying hard to show my supervisor that I was “poor enough” to understand my patient, by telling my supervisor how my family struggled when we first moved from Puerto Rico.

Toward the end of the second year of therapy, Ms. B seemed more comfortable expressing her emotions. Yet there were ways in which the therapy had not moved forward. When I reviewed a videotape of a session with my supervisor, she remarked that Ms. B seemed younger than her stated age and that she was speaking in a tone typical of a little girl. It became clear that I was continuing to be supportive and “cheerleading,” even though Ms. B seemed ready to tolerate more. In supervision, I realized that I was enacting a mothering role rather than interpreting the patient’s need for mothering and experiencing her transferential anger at not receiving it. The patient had needed a supportive phase of treatment to learn how to take care of herself and to titrate the closeness in our relationship. Now that she was healthier, however, I needed to inch back toward closeness with Ms. B. In retrospect, the turning point came when I realized I was enacting a mothering role and then asked the patient to describe ways in which women take on this role in her own family and in Hispanic cultures in general. It was only then that I could begin to understand why I was avoiding discussing the patient’s anger toward her mother.

In Hispanic culture, men are raised as the center of the family, while the mother and daughters do the caretaking. In my own extended family, this was definitely true. Over the years, I had learned to switch this stance on with family and off professionally, traversing two cultures without realizing it. In many male-centered Hispanic cultures, the women stick together, supporting each other and focusing their energy toward the men. Female loyalty can preclude exploration of ambivalent feelings among women. It gradually became apparent to me that I, like the close-knit women in Hispanic families, had colluded with Ms. B in focusing more on her romantic struggles with her boyfriend than on her conflictual relationship with her mother. Nevertheless, I began to realize that Ms. B’s relationship with her mother was at the center of her fears about attachment and dependency—and thus, that we needed to explore it.

With this realization, I started to ask Ms. B more about her relationship with her mother. As I did, Ms. B began to share with me her family history—not the history of their psychiatric problems, but the history of the romantic tragedies of the broken women in her life. While taking this history, I was aware that this was Ms. B’s version of her family history, which, in fact, sounded almost like a folktale. The story began in a small adobe hut in rural Ecuador, where Ms. B’s maternal grandmother lived. According to Ms. B, the neighbors were jealous of her grandmother’s beauty. They gave her grandmother a magic perfume that cast a spell on her. After her grandmother gave birth to her mother, she started seeing things, wandering away from the house. Her grandfather would bring priests to exorcise her, but nothing worked. Magically, when she was pregnant, she would be relieved of the curse. When B’s mother and her 9 younger siblings went to school, the other children would tease them about their “crazy” mother.

Ms. B’s mother grew up and met Ms. B’s father in the local town square. Ms. B’s mother, who was also quite strikingly beautiful, fell passionately in love with Ms. B’s father. He was older and dressed very nicely. It was not until their wedding night that Ms. B’s mother discovered that her new husband had been wearing shoe lifts throughout their courtship, and

he was actually much shorter than she was. Ms. B's mother became pregnant with Ms. B and soon discovered another tragic flaw in her husband, a penchant for gambling. She remembered how her father lost the money they were saving for Christmas presents. Ms. B's mother always bitterly complained to Ms. B that she had been "duped." Ms. B would often see her mother as "broken, sad," suffering bouts of depression. Ms. B saw that other women in the family had also been swept away by love, only to become depressed by the reality of their ne'er-do-well husbands.

As for Ms. B's own romantic life, she remembered an incident in which she had asked her mother if she could go to the town carnival with a handsome boy. Her mother started crying and convinced Ms. B to stay at home. Ms. B's mother worried that the 19-year-old high school dropout and "loser" would woo and "dupe" Ms. B. She added that she was grateful to her mother, since he would have been "a bad person to fall in love with." Ms. B explained that the only way to protect herself from the dangers of being "swept away" and falling in love was to enter a "rational, loveless" relationship. She believed she could be protected from this fate by keeping a long-distance relationship with her boyfriend. She stated she would not allow herself to fall in love with him until she moved south to marry him.

To Ms. B, this cultural folktale showed a pattern among the women in her family. Ms. B's perception is that all of the women in her family would fall in love with "losers" who ultimately sucked the life out of them. By understanding this formulation, Ms. B was able to link her fear of an intimate relationship with her boyfriend to the assumption based her family's folktale that she would be broken and depressed if she allowed herself to fall in love and marry. This explained why Ms. B felt that marrying her boyfriend would be like "death," since such a marriage would lead Ms. B to become like her mother, which would be like death.

As we drew parallels between real life situations in her childhood and her current conflicts, Ms. B's dress and voice, usually childlike, began to change. She began dressing more like an adult woman, showing her figure and wearing her hair down, clearly embracing a grownup appearance. Also, 1 month before this presentation, we observed a similar transformation in her transference to me. She began the session by talking about the clock above my head. She told me that the 5-minute "warning" I gave her was a symbol of my taking care of her. She feared that if she took on the role of keeping an eye on the time, she would be an adult caring for herself, but nobody else would be looking out for her. She went on to wonder if she picked people who did not take care of her, specifically picking boyfriends who did not take care of her because she did not expect it. When I asked her how her culture played into this notion, she said that although the traditional male role was to protect and provide, she did not see that growing up. In her own nuclear family and those of her paternal aunts, families were female driven.

In summary, being of similar cultures initially felt "too intimate" or "too close," resulting in a year of "distance." Although supportive techniques helped the patient tolerate the closeness of psychodynamic therapy and exploration of our shared culture, I also used them defensively. Realizing I was avoiding the anger toward the mother, I was able to enter the world of the patient's folktale, which ultimately led to understanding her fear that she would become a depressed, broken caretaker if she fell in love and married her boyfriend. This interpretation helped Ms. B improve the quality of her relationships.

Case Discussion

Dr. Deborah Cabaniss (Supervisor)

In July of 2007, I was assigned to be Dr. Rodriguez's third supervisor for this case. This change was routine; our program assigns new supervisors each year. While potentially disruptive, this procedure provides the therapist with a new pair of supervisory "eyes" each July. To familiarize me with the case, Dr. Rodriguez presented the patient and offered me copies of her previous write-ups. Both presentation and write-up indicated that the patient was intelligent and professionally motivated, with good ego function, psychological mindedness, and the ability to engage in a psychoanalytic psychotherapy. For additional information about the case, I asked Dr. Rodriguez to begin taping the sessions, which she did with the patient's consent.

As Dr. Rodriguez mentioned, the first videotaped session revealed the patient to be talking in an immature manner and the therapist to be offering suggestions rather than exploring the patient's thoughts and feelings. The predominant object relationship was of an insecure child with a kind, overtly encouraging mother. I shared this observation with Dr. Rodriguez, and we began to wonder why this was. Was the patient's ego still quite fragile, despite her evident gains? Was the therapist inhibited in her attempts to undertake a more psychoanalytic psychotherapy? I did not yet have the answer.

Around this time, in an early supervisory session, Dr. Rodriguez told me more about the patient's early history of deprivation. Noting that patient and therapist both had Hispanic names, I asked Dr. Rodriguez about her own background. In telling me, she emphasized the financial difficulties that her own family had had. As I talked to Dr. Rodriguez about this, I noticed that I was being careful about my pronunciation of Spanish words in particular, that I was rolling my r's, and I became self-conscious of my non-Hispanic background. Once I realized that I was doing this, I began to wonder why. Was I trying to show my Hispanic supervisee that I understood something about her culture? Did I feel left out of the Hispanic dyad of therapist and patient? Was I having a moment of anxiety that the therapist would have been better off with a Hispanic supervisor? Although I did not yet fully understand my behavior, I did know that I was engaged in a *parallel process*, which, if understood, would teach us something new about the case, perhaps about the somewhat unexpected object relationship I had observed.

The concept of the parallel process was first described by Harold Searles in 1995 (1). Searles described the situation in which the therapist unconsciously identifies with something that has been stirred up in the patient and then enacts it in the supervisory relationship. He called the process by which the supervisor understands this the "reflective process," and he felt that it often illuminated unexplored dynamics in the therapeutic relationship. As with the concepts of transference and countertransference, parallel process has been defined over the years in broader and narrower terms (2). The narrower view, espoused, for example, by Baudry (3), posits that "true" parallel process only exists when the dynamics of the patient and therapist match. The broader view, which Searles advocated, is that any therapist can identify with any patient with subsequent enactment in supervision. Adopting the broader view enables the supervisor to address the situation focusing on the patient, rather than on the therapist's personal issues. It also encourages the supervisor to make broad use of his or her feelings during and about the supervision in order to best understand the case, educate the therapist, and help the patient.

Using the "broad" definition of parallel process, it was clear to me that this was operating in the supervision. But what was the parallel process, and how could it help me to understand the dynamics of the case? The therapist was clearly identifying with the patient, in

particular, her early deprivation—but she was enacting rather than describing the identification. I, in turn, was trying to demonstrate my knowledge of Hispanic culture to the therapist. We were both trying to be something that we were not and to be close in an ethnicity that we did not actually share. I realized that this was most likely happening in the therapeutic situation as well, that the therapist and her patient were presuming closeness because of their ethnicity rather than exploring the patient's feelings about their differences. The patient had had a desperately deprived childhood, while the therapist had not; the patient was an academic fledgling, while the therapist had a Ph.D. from one of the finest universities in the country; and the patient was struggling with very disturbed object relations, while the therapist was happily married with a small child. Here was the answer to the therapist's cheerleading: "You are just like me," wished the therapist, "so all you need is encouragement." This avoided the pain on both sides of the therapeutic relationship of acknowledging the marked disparity between the functioning of these two young women and of paving the way for the shame and potential envy that this acknowledgment could spark. The patient and therapist's denial of the vast differences between them was thus enacted in their presumption of sameness in their ethnicity that we were enacting in the parallel process.

Realizing this helped me to focus the therapist in several important ways. First, I suggested to the therapist that she and the patient were presuming a "sameness" of ethnicity rather than exploring the patient's unique experience of her cultural background. The therapist illustrates this, for example, in her presumption of the meaning of "Catholic guilt." Abandoning this assumption allowed the therapist to begin asking the patient much more about her unique cultural background. Second, it allowed the therapist to step back and to realize that her fear of merging with the patient had led to her initial avoidance of cultural issues. Understanding this allowed the therapist to shift discussion of cultural issues from only occurring in supervision to occurring directly with the patient in therapy. Finally, and perhaps most importantly, it allowed the therapist to realize that the patient needed more than just encouragement to overcome her inhibitions, since her early object relationships, unlike those of the therapist, were profoundly disturbed and had produced a pattern of self-destructive object choices that would take time and effort to repair.

Dr. Maria Oquendo (Grand Rounds Discussant)

The chief complaint is a wonderful red herring, since one could imagine this presenting complaint as coming from a young woman from just about any culture. On the face of it, this therapy could have been conducted in a "culture-blind" manner, focusing on the "universal problems" of dependence and autonomy. Instead, the therapist embarked on a courageous journey exploring the role of culture in the psychotherapeutic process (4–13) with the patient that led to both patient and therapist growth.

We assume that similarity in background and language result in better services. Efforts in public health policy are being promoted to make this more possible. Communication can be enhanced and cultural issues may be easier to address. However, little attention has been paid to the pitfalls of such a situation. For example, there are key issues around language of training for the therapist. The therapist may feel less doctorly or even articulate in his or her native language if it is not the language of training. In addition, during training, we learn to listen for both content and process. Process listening, such as is used to identify evasions, defenses, or associations, is likely language-based and may not be easily accessible without specific training in the language in which the therapy is conducted (14). Difficulties may also arise if the therapist assumes that he or she "knows" what the patient means and expends less effort in exploratory work. This is illustrated in Dr. Rodriguez's assumption that she knew what "Catholic guilt" meant to the patient. On the other hand, the therapist may assume that the patient will be more open about culture-specific ideas because he or she

expects the therapist to understand. However, the patient may nonetheless avoid topics that a clinician would consider superstitious or strange, such as folk beliefs, because the patient anticipates that the therapist may consider the patient “primitive” or “uneducated.”

An illustration of the way in which cultural similarity may actually result in *less* understanding occurred when Dr. Rodriguez did not notice the patient’s use of words with double meaning. Although the use of double entendre is common in Spanish, women are socialized not to “pick up” on that type of material, allowing them to preserve their “dignity” and not be offended by the “cat-calling” they are subject to on the street. This likely contributed to Dr. Rodriguez’s “not hearing it” at first. In fact, I imagine it would not have happened if the patient were speaking English. There are also times when literal translations from one language to the other can be misleading (14). Because words can have multiple meanings, culturally specific meanings may be lost.

As therapists, we have no qualms about pressing people to stay on topics that make them uncomfortable. In this case, however, when the patient spoke in Spanish about the flirtatious neighbor, the therapist did not press her to speak more about this. It may be that even this brief use of Spanish shifted the therapist’s stance from that of the probing clinician to that of the polite listener. This may reflect the fact that when therapists who are trained in English shift to their native language they may shift into the cultural mores that they associate with that language.

Of course, knowing the patient’s language can also be useful. The literature suggests that individuals have access to different memories in different languages. At the same time, as Dr. Rodriguez and her patient experienced, speaking the mother tongue can be extremely anxiety producing. In fact, the use of English, the non-native language, may allow the patient to “regroup” and to temporarily restore higher-level defenses. Our work in psychodynamic therapies is to allow patients to explore fantasies and primitive wishes, which often induces regression. In this case, the patient’s use of Spanish-induced anxiety in the patient, which Dr. Rodriguez experienced via projective identification when she felt like the floor was “falling out.” Recognizing this, Dr. Rodriguez and her supervisor appropriately took a step back and redirected the therapy toward a more supportive approach. This interaction between Dr. Rodriguez and her patient was an excellent example of access to different feelings depending on language.

The struggle between closeness and “appropriate therapeutic distance” was also illustrated in the conundrum about the hug after Dr. Rodriguez had her baby. As Dr. Rodriguez points out, in Hispanic culture it would be cold to not hug someone who had just had a baby. Negotiating these transactions is tricky and warrants examination for each individual patient.

Dr. Rodriguez realized that because of their cultural similarities, she was colluding with Ms. B in not addressing the negative maternal transference. As Dr. Rodriguez focused on the male-centered Hispanic culture, she enacted the familiar role of the “women sticking together.” Although this “maternal enactment” may have been supportive, it is also important to note that in many Hispanic cultures the young girl often gets mixed messages from the mother, who may be loving yet insistent that the woman’s role is to serve the men. I think that Dr. Rodriguez was trying not to be this type of Hispanic mother.

It is likely that the issue regarding Dr. Rodriguez’s countertransference of “wanting to be Spanish enough or poor enough” in order to better understand her patient was picked up because of her supervisor’s sensitivity to cultural issues and knowledge of Spanish and Hispanic culture. We use parallel process often in understanding dynamics, but it requires awareness on the part of the supervisor. In learning how to construct cultural formulations,

residents should have an opportunity to work with supervisors who are tuned in to these issues and interested in discovering cultural aspects of presentation and treatment with the resident so that they can develop these skills.

Conclusion

Cultural similarities in the therapeutic dyad can enhance the treatment by facilitating understanding regarding cultural traditions and language. However, the similarities can also be a hindrance and attention to the process remains paramount. Simply assuming that cultural matching invariably enhances treatment may undermine the ability to recognize pitfalls related to cultural issues for the therapist. A balanced observation of transference and countertransference, bolstered by attentive supervision, can remediate such potential problems.

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