Failed expectations: When cultural similarities do not favor a therapeutic bond

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The importance of establishing a bond with a patient early in treatment is instilled in psychiatry trainees during their first year of residency. It is well-known that a strong therapeutic connection is correlated with successful treatment and favorable outcomes.[1] But what if social and cultural factors that could provide an almost immediate familiarity threatened the therapeutic alliance?

We present a case in which sharing my cultural background with a patient was detrimental to the therapeutic relationship and forced me to look beyond superficial similarities to forge a meaningful connection.

A shared language, a shared connection?

When I, a psychiatry intern who emigrated from Honduras 11 years ago, met Ms. M, a middle-age, Spanish-speaking Honduran immigrant with schizoaffective disorder, I was curious to hear the story of how her immigration intermingled with her mental illness. As a budding psychiatrist, I was certain our common culture would intensify our interactions. It did, although in ways I did not expect.

Despite my enthusiasm and best intentions, our first meeting was less than ideal. Ms. M believed she not only was God's wife and my attending physician's wife, but that I was her rival for my attending's affections. "I heard you are from Honduras. I am from Honduras, too. What part are you from?" I asked her. She became angry. "I am not from there. I am from Israel," she said. For many days, we had the same hostile and disappointing conversations, during which I would try to tease out the basis for her delusions and understand our lack of connection. I felt hurt and puzzled. If I could not connect with someone with whom I shared a common background, then to whom could I connect with? I had to re-evaluate my approach. Should I alter my attire to seem less feminine? Should I tell her I am happily married? Should I not speak Spanish? Would these changes make our interactions feel less threatening to her?

"You are focused too much on *you* and not enough on *her*," my attending retorted. I came to realize that, in my crusade to have Ms. M perceive me a certain way, I had lost sight of who she was and what lay at the core of her delusions. I stepped back and considered Ms. M: a patient, yes, but also a woman who was unable to communicate freely with others because she did not speak English. Because of her perpetual paranoia and psychosis, she was emotionally isolated, lacked necessary social support from her family, and had no sense of community. However, in her delusions she was a prophet, a herald for

God's news, with a vital role in His plans. In her mind, she was a mother and had the support of a life-long partner.

As I considered her struggles, I thought about myself. When I first came to the United States, it was difficult to develop relationships with my peers because I worried about my accent and idioms. In Honduras, my friends and family knew me as a gregarious, quick-witted individual. In acculturating to my new home, I became reclusive and insecure. It took years to regain a semblance of identity.

In my attending's office, I found that it was not our shared heritage that was the path to engaging Ms. M, but rather our shared isolation, which I had not been validating. This helped me reframe the way I viewed the therapeutic relationship and changed the focus of my attempts to engage her. I stopped taking her rejection personally and focused on providing her support and solace. By tapping into her isolation, she opened up and eventually agreed to medication changes, which slowly reduced—but did not eliminate—her delusions, hallucinations, and hostility toward others. Because of her intractable psychotic symptoms, she required a long-term structured care setting and was transferred to the state hospital.

Culture is only 'skin deep'

I assumed our shared background would have effortlessly led to a trustworthy relationship, but her resistance challenged that notion. My own desires to have a deep connection with a fellow immigrant contributed to my internalization of her rejection. Our physical and cultural similarities acted as a hindrance because she subconsciously projected her idealized image of a woman onto me. Nevertheless, she helped me recognize the importance of unexamined projective identification and countertransference, evidenced by wanting to change my appearance and behavior and my increased willingness for self-disclosure.

As I start my second year of residency and reflect on my experiences as an intern, Ms. M always comes to mind. She taught me that culture may be only "skin deep" and similarities between therapist and patient do not guarantee a successful bond. Searching for deeper, fundamental connections and validating these bonds can open the doors to connecting with those from all walks of life, from whichever road they come.

Reference

1. Krupnick JL, Sotsky SM, Simmens S, et al. The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin Psychol. 1996;64(3):532-539.

Clinical Point

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