Editor:

I have had an interest in cross-cultural psychiatry for a long time, especially in the realms of religion and spirituality, such that the article by Dr. Boehnlein and colleagues[1] on the use of the cultural formulation in forensic evaluations and Dr. Ezra Griffith's commentary[2] on personal narrative and medical ethics, were of particular interest. I found the concepts of "authentic representation," "authenticity," and "belonging," thought provoking in several ways.

First, these concepts apply not only to ethnicity and profession, but also to the myriad of subcultures to which a person belongs. How does one balance representing multiple, even competing groups? Using one friend as an example, I would assume she perceives herself as belonging to the dominant ethnicity in the United States, white, as well as having a professional identity as a physician. I also assume she perceives herself specifically as a physician trained in psychiatry and family medicine with a special advocacy and expertise in addiction medicine. In addition, she identifies herself as belonging to the Goth subculture, particularly in her enjoyment of certain role-playing games. Goth values of individuality and nonconformity may be difficult to balance with those of physicians, but she seems to pull if off with little struggle in her identity or impact on her professional success.

Second, I found myself reflecting on my wife's family and experience. She is also a dual-boarded family practice/psychiatric physician, and a fourth-generation Japanese-American. As far as I can tell, she and her family have little difficulty with their sense of belonging to the "dominant" (i.e., white) group. However, my wife tells a story of the first time she felt "different" or "not belonging." Her family was stationed in Alabama while she was in grade school. One day, the school had a "cultural day" and all the children brought food from their "cultures"; she brought a Japanese dish. One friend of hers remarked, "You're Japanese? I thought you were black." My wife was the only Asian child in an otherwise black and white school. Her childhood friend had assumed that since she wasn't white, she must be black. It was the first time that it occurred to her that, as an Asian-American child, she did not really belong to either group.

Finally, my own effort to address culture and ethnicity in psychiatric practice has been a struggle at times. While reading Dr. Griffith's discussion of the spectrum of authentic representation, I recalled an interview of a patient who remarked that he was the only African American in his military unit. Later in the interview, I asked, "You mentioned being the only African American in your troop. Did this affect your experience in the military?" He replied that he did not see people as black or white but just as Americans doing a job. I was a bit nonplussed by his disregard of what I thought could be an important area to explore. Because I was anxious about addressing ethnicity anyway, his reply did not help to overcome my discomfort. More recently, I considered this concept when a resident rotating through my service made a presentation entitled, "Asian-American Combat Veterans and PTSD." She pointed out how some Japanese Americans during WWII distanced themselves from their Japanese heritage in an effort to represent Americans more than the enemy they physically resembled. She also made the point that of the last few wars in American history, the "enemy" has all been Asian, and discussed how this affected the experience of some Asian-American soldiers.

There is more in Dr. Griffith's article that has captured my interest (e.g., the impact of spiritual and religious experience) as well as Dr. Norko's commentary on compassion,[3] but it was these three concepts—authentic representation, authenticity, and the process of belonging—that I have found most helpful in organizing the observations and thoughts I've detailed herein.

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