Hybridity and intersubjectivity in the clinical encounter: Impact on the Cultural Formulation

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Abstract
Most case studies of the cultural formulation have focused on encounters with a single clinician. This article examines the assessment of a patient across different settings in which multiple clinicians developed separate understandings of the patient's identity. The formal cultural formulation prepared by the last clinician to work with the patient revealed a vastly different picture than what was previously recognized, reflecting both the impact of the identity of the clinician and the systematic evaluation process on the nature of the patient's responses. This suggests that cultural hybridity can stimulate new modes of inquiry as people integrate disparate cultural references to fashion a new identity. Intersubjectivity can also alter information elicited by clinicians. The conclusion highlights the need for practice guidelines for use of the cultural formulation across treatment settings.

Keywords
cultural formulation, identity, intersubjectivity, hybridity, psychiatric history, cultural theory

The DSM-IV Outline for Cultural Formulation (CF) addresses the importance of culture in psychiatric evaluation (Lewis-Fernández, 1996). Collecting the information needed for a cultural formulation depends on general interviewing skills and exposure to specific content from diverse cultures (Lewis-Fernández & Díaz, 2002). Although some educational materials have been produced, the location of the CF in an appendix of the DSM-IV has hampered its widespread use (Lu, 2006). There has also been criticism of the CF in that it tends to divide cultural information from...
the general clinical assessment (Alarcón et al., 2004), reifies culture (Kleinman & Benson, 2006), its subsection definitions are vague (Ton & Lim, 2006), and busy clinicians may avoid it if it adds time to assessment (Lewis-Fernández, 2009).

Acknowledging these shortcomings, more detailed guidelines with recommendations for specific interview questions (Mezzich, Caracci, Fabrega, & Kirmayer, 2009) and strategies to embed the CF in the general history of the patient (Caballero Martínez, 2009) have recently been published. This work assumes that different clinicians can apply a cultural formulation interview in a more or less consistent way. To date, however, little work has examined situations in which different clinicians assess a patient or access a patient’s medical record. For example, in inpatient institutions where patients travel through different units, do all clinicians perform a cultural formulation interview? If so, do they obtain the same results? In particular, given that cultural identity and other cultural information may be intersubjective in nature, emerging out of the clinical encounter, does the CF need to address these nuances?

Two concepts influenced by contemporary psychodynamic theory can foreground these issues. Hybridity, the mix of different anterior objects to create a new entity, has influenced disciplines throughout the sciences and humanities (Hutnyk, 2005), with the idea of cultural hybridity surfacing after the 1800s as European colonists debated reproduction with other races (Young, 1995). Recently, the postcolonial theorist Homi Bhabha has postulated hybridity as synthesized identities:

The move away from the singularities of “class” or “gender” as primary conceptual and organizational categories, has resulted in an awareness of the subject positions—of race, gender, generation, institutional location, geopolitical locale, sexual orientation—that inhabit any claim to identity in the modern world. What is theoretically innovative, and politically crucial, is the need to think beyond narratives of originary and initial subjectivities and to focus on those moments or processes that are produced in the articulation of cultural differences. (Bhabha, 2006, p. 2)

Hybridity relates fundamentally to articulating cultural identity, a critical element of the CF. The move beyond initial subjectivities in acknowledging cultural differences recalls the theory of intersubjectivity, a framework in which subjective reality is recognized as created by the interaction of clinician and patient in the psychological field between them (Stolorow, 1988). Intersubjectivity replaces classical psychodynamic understandings which tend to contrast the subjectivity of the patient with the objective perspective of the clinician, and to posit an unchanging mind grappling with drives and urges, for a view of the clinical encounter as a process of mutual acknowledgment between independent individuals, in which meanings derive from changing selves and interpersonal relations (Benjamin, 1990; Dunn, 1995). The notion that relationships are as essential to humans as biology (Kirshner, 2006), challenges the idea of an isolated mind (Stolorow, 1991). Consequently, transference and countertransference refer to subjective experiences
of the relationship as experienced by patient and clinician (Stolorow, Atwood, & Ross, 1978). Analysis of this relationship is another critical element of the CF.

This paper addresses the mutable nature of cultural identity (hybridity) based on the dynamics of the clinical relationship (intersubjectivity) by following one patient through the psychiatric emergency room (ER), the inpatient unit, and the psychosocial residential rehabilitation treatment program. First, I present the case of Mr. Raju through the standard clinical assessment. Next, I contrast my formal CF against with the informal cultural designations made by previous clinicians to appraise the CF’s contributions (Bäärnhielm & Rosso, 2009). Afterward, I discuss the roles of hybridity and intersubjectivity in Mr. Raju’s case. I conclude by advocating for their study in the clinical encounter. I obtained permission to publish this case by assuring the patient of confidentiality through anonymized identifying information.

The clinical case

This presentation combines information from Mr. Raju’s stay on different hospital wards. He spent one night in the emergency room, 3 weeks in the inpatient unit, and 4 weeks in a partial-hospitalization program. I was his primary clinician in the partial program until his discharge. We met weekdays, for 5 to 15 minutes daily, to check his progress with activities of daily living, sobriety, housing, and employment. Our daily meetings focused on his therapeutic goals.

Identifying data

Mr. Raju is a right-handed, English-speaking, single male veteran in his early thirties, currently unemployed, but formerly a health officer for the U.S. Army. He is from an upper middle-class family from India, and first arrived in the USA about 10 years ago. He has had persistent acculturation problems.

Chief complaint

“I’ve just really fucked up... I drink as much as I can get... I cannot handle civilian life... Cannot sleep and have nightmares about the Middle East.”

History of present illness

A female cousin brought Mr. Raju to the veterans hospital for depression, suicidality, and polysubstance dependence. He could not transition into civilian life after returning from Iraq 3 years prior to our initial interview, and was drinking alcohol daily until blacking out despite many attempts to quit. He smoked marijuana if alcohol did not produce desired effects. He used crack cocaine and ketamine without pattern to “block out” memories. He denied hallucinations, but experienced nightmares and flashbacks several times weekly. He often felt uncontrollable irritability and became hypervigilant when “cornered.” He also experienced guilt and
regret about caring for prisoners tortured by his unit. Despite financial assistance from the military and his family, he was evicted from three apartments over the past year for late rent. He could not adjust to civilian life, but threatened to kill himself if sent for a third tour. He wanted to move away from others or “live in the woods to be with God.”

His cousin disputed his denials of self-injury, adding that he cut his arms with a sharp object and had cigarette marks on his chest. She hinted that his fears of persecution could be related to drug dealers demanding money from him. He left college 2 months prior to our interview due to depression, nightmares, and repeated intoxication leading to two car accidents. Around the same time, alone and broke, he chastised relatives during a family celebration, estranging everyone except this cousin. He had resided illegally for 2 months in an apartment, and had been evicted on his day of hospital presentation.

**Past psychiatric history**

He had no previous hospitalizations. His first psychiatric contact was 2 years before the initial interview for substance use counseling.

**General medical history**

He suffered an ankle fracture during deployment. He lost consciousness in a car accident as an adolescent in India. He stated that the “brain scan was negative” and had not noticed any impairment.

**Substance abuse history**

He started drinking alcohol at the age of 18 in India. He drank 1/2 to 3/4 liters of whiskey daily to lose consciousness. During his first 6 months in Iraq, he stayed sober, his longest period of abstinence in adult life. He received counseling during his second deployment to Iraq after using ketamine and cocaine with alcohol. He started marijuana upon military discharge.

His first psychiatric treatment occurred 2 years before his admission, as a result of a conviction for driving intoxicated and involved a court-mandated weekly outpatient program of 4 months duration. He completed this program successfully, but presented to the ER for intoxication 8 months prior to our interview. After one dose of antipsychotic medication and detoxification overnight, he was discharged the next day.

Four months before this admission, he presented intoxicated after an eviction, refusing lodging in a “civilian shelter.” He drank 10 cans of beer daily alone at home, avoiding stressful situations. He demanded that the veterans hospital “do everything, since [he] gave everything to serve this country.” He felt suicidal “all the time” but would not elaborate. Occasionally, he said “I’m a trained killer,” but did not target anyone specifically. After one night of detoxification, he was discharged.
Social and developmental history

Mr. Raju was born in New Jersey to Indian immigrants. His mother died when he was 3 years old; he refused to discuss her death. He and his father moved to India where his father remarried 1 year later. He would not discuss his father and stepmother out of anger. He attended Catholic boarding schools in India until the eighth grade, excelling in sports. In ninth grade, he moved to the USA. He returned to India to finish grades 11 and 12 at boarding school. He said he felt like a loner until he found drug mates at the age of 18 during a gap year. At 19, he entered medical school in India. He failed his first year due to drug use and remediated for 3 years before enrolling in the American military. His highest education is an associate degree in chemistry. He was a university senior studying science until leaving 2 months prior to the initial interview for substance treatment. He was deployed to Iraq with the Army from 2003 to 2006 for two tours. He did not fight others, but was exposed to convoy attacks and improvised explosive devices. He was a public health officer for American soldiers and received an honorable discharge, but had not worked since. He had no previous jobs, current finances, savings, or income.

He was single and had no children. He denied recent interpersonal losses. He also denied any abuse. He had one legal charge for driving intoxicated and injuring a passenger, spending 3 nights in jail.

Family history

His father and maternal grandfather became alcoholics after his mother’s death. There was no other history.

Physical examination

Physical examination was unremarkable.

Mental status examination

Mr. Raju was well built and nourished, avoiding eye contact initially. He was awake and alert. Guarded at first, he gradually became more cooperative over the course of our meetings. His motor and speech activity were normal. He spoke with a slight Indian accent. His speech was spontaneous, fluent, and goal-directed, but he would not answer many questions he deemed “too private.” His mood was activated with exclamations like “You gotta help me, Doc!” when outlining tasks requiring effort. His affect varied from calm to inappropriately buoyant, with smiling and singing during the interview. His thought processes were linear and coherent. There were no symptoms of anxiety or psychosis. Initially, he expressed passive suicidality without a plan. There were no homicidal thoughts. His attention, memory, concentration, and general knowledge were intact. His insight and judgment were fair, but he often tested limits with provocative questions (e.g., “What will you do this weekend to stay
sober, Doc?!!”; “Are you married or not?!”; “Can we go out for lunch sometime after I get out of the hospital?!”).

**Course and outcome**

Mr. Raju improved since he was given supplemental multivitamins, thiamine, folate, and a benzodiazepine taper for alcohol withdrawal in the ER. A head computed tomography (CT) for his trauma history was negative. He was admitted for detoxification, suicidality, poor impulse control, and symptoms of posttraumatic stress disorder (PTSD). He asked to be restarted on a selective serotonin reuptake inhibitors (SSRI) from his last course of treatment that had decreased his anxiety. This medication also relieved his depression, nightmares, and flashbacks. Over 2 weeks, his affect brightened. After 3 weeks, he was referred to a partial-hospitalization program to find housing. He was maintained on this SSRI, an antihistamine medication for insomnia, and a beta blocker for vital-sign stability. He stayed sober throughout the program, but doubted his commitment on discharge. For this reason, he refused agents that decreased cravings. He named sobriety, housing, and employment as his treatment goals. Four weeks after starting the partial program, he was discharged to his aunt in New Jersey pending employment and housing referrals.

**DSM-IV diagnosis on discharge from the inpatient unit**

Axis I: Major depression, recurrent, moderate; rule out (r/o) substance-induced mood disorder.
Posttraumatic stress disorder, acute.
Alcohol dependence, in early full remission, in a controlled environment.
Polysubstance abuse (cannabis abuse, cocaine abuse, ketamine abuse).
    r/o psychotic disorder secondary to ketamine abuse.

Axis II: r/o schizoid personality disorder.
    r/o schizotypal personality disorder.

Axis III: Head trauma.
    Right-ankle fracture.

Axis IV: Problems with primary support group.
    Problems with occupational and financial supports.
    Homelessness.

Axis V: GAF 60 (on discharge).
The cultural formulation compared to informal assessments

Below, I contrast the informal cultural designations of previous clinicians with my formal CF. This exercise serves three functions. First, it situates Mr. Raju’s suffering in his world. Second, it details information from the CF otherwise absent from clinical assessment. Third, it shows how clinicians variously rationalize patient information, signifying the intersubjective nature of knowledge.

The cultural characterizations of previous clinicians

Seven psychiatrists treated Mr. Raju throughout his 7-week stay: three Euro-American physicians in the ER, one Pakistani American and one Vietnamese American physician in the inpatient unit, a Euro-American physician who screened him for partial hospitalization, and I, an Indian American psychiatrist. While all psychiatrists appreciated the role of culture in symptomatology, no other psychiatrist performed a CF, suggesting an area of improvement for cultural psychiatrists.

Mr. Raju was deemed “Indian” at the ER. The evaluating physician believed that cultural information, though interesting, remained secondary to his suicidal depression, hypervigilance, and substance abuse. The evaluating physician asked about his origins during the social history, leading to his initial description as “Indian.” Other psychiatrists did not change his description as “Indian.”

His inpatient psychiatrists were Asian Americans and conducted fuller social and educational histories. Their notes labeled him as “Indian American.” Given his frequent moves between India and the United States, this would seem warranted. Nevertheless, the designations “Indian” and “Indian American” changed based on clinician.

The formal CF clarified his identity very differently. Our discussions furnished material that honed treatment planning during partial hospitalization and discharge. Surprisingly, he rejected the ethnic identities of “Indian” and “Indian American.”

Cultural identity of the individual

Cultural reference group. Mr. Raju first said: “Doc, like you, I’m just another brown man trying to survive in this White country.” “The military really dissolves those [racial] distinctions,” he once explained. He clearly identified as a veteran and agreed that the military was his predominant cultural reference. However, he regarded the military ambivalently. While he befriended soldiers in the ward, he blamed deployment for his symptoms. Thus, the military was a source of both support and stress.

Language. Mr. Raju spoke English fluently, learnt during childhood in the United States and education in India. He understood enough Hindi to enjoy Bollywood
films and exchanged Telugu with relatives. Mr. Raju used language for emotional intimacy. For example, he initially addressed me in Hindi in front of others. As he struggled with fluency, I invited him to meet privately. When asked why he switched languages, he expressed a desire for friendship, since he missed Indian friends. He agreed that English would allow him to express himself easily.

**Cultural factors in development.** He repeatedly referred to challenges in social relatedness. He detested being labeled an “American” in India, only to be labeled “Indian” in the United States. His boarding school education reinforced his marginality. He hated his transition to a new high school since it was harder to make friends. His enrollment in medical school demonstrated his elite status. In the military, his public-health work heightened feelings of difference from peers.

**Involvement with culture of origin and host culture.** Mr. Raju lived between cultures. He maintained his original culture by occasionally eating Indian food, watching Bollywood films, and speaking Indian languages. He used to visit relatives in New Jersey for major Hindu holidays. His involvement with his host culture deteriorated from attending college to staying alone in his apartment. He viewed himself as an agnostic Hindu among a majority of Christians. He mostly ate frozen American food such as hamburgers and hotdogs, since he did not cook. He sometimes watched American television and listened to rock and rap music. Notably, he befriended other veterans in the hospital, implying a wish for more social contact.

**Cultural explanations of the illness**

**Predominant idioms of distress and local illness categories.** Mr. Raju’s predominant idiom of distress was the expletive, as in “I’m really [expletive] up, Doc!” The phrase conveyed the level of distress rather than type. There were no other illness categories.

**Meaning and severity of symptoms in relation to the cultural norm.** Like other soldiers, Mr. Raju blamed the military for his mood and substance disorders. He denied depression or anxiety before enlistment, but admitted to recreational substance use. His failures in civilian life, especially college termination and the potential for redeployment, triggered depression. He used drugs to avoid thoughts about war and social isolation. The meaning and severity of his symptoms matched hospitalized peers. However, he felt frustrated when his family mentioned that other veterans adjusted to civilian life without psychiatrists.

**Perceived causation.** Mr. Raju traced his depression and anxiety to deployment: “I was a flower going in and when I came out, I had all of these thorns on me!” His hypervigilance and avoidance started in Iraq. His depression worsened on not assimilating to civilian life.

Regarding substance use, Mr. Raju downplayed the inheritability of alcoholism. He conceded that his father and grandfather became alcoholics after his mother’s
death, but he believed his alcohol dependence started from depression. He often insisted, “Doc, I can quit when I want!” despite concerns about relapse. He stayed sober for veteran housing programs and was checked twice weekly with random breathalyzer tests. However, he never admitted losing control to substances.

Cultural factors also figured in causation, particularly through the absence of protective factors. His migration distanced him from his nuclear family and he was only loosely connected to relatives, so he had no close confidants or pressures to dissuade alcohol consumption. He did not identify with a Hindu sect or religious congregation that discouraged alcohol.

Help seeking. Mr. Raju did not independently engage psychiatrists or traditional healers, but he did not resist when his cousin accompanied him to the ER. He spoke favorably of previous psychiatrists.

Cultural factors related to psychosocial supports and level of functioning

Stressors. Mr. Raju’s prolonged social isolation effectively eliminated active stressors. His most immediate stressor was his landlord who demanded rent money. His cousin suggested that drug dealers could be another potential source of stress. Over the course of our meetings, however, it became clear that he conceived of psychosocial stressors as the lack of active supports and grief around unresolved interpersonal conflict. He openly regretted his mother’s death. His relationship with his father was ambivalent, especially after remarriage. Mr. Raju discouraged conversations about romantic relationships. Upon returning to the United States for high school, he found adjustment difficult, moving each year to a different school. His boarding schools in India dissuaded friendships among men and women. His interest in sex deepened in medical school where he found women to “get high and party.” An avowed heterosexual, his history lacked any emotionally committed relationships. He drew upon relatives in New Jersey for support after military service, but excessive drinking strained his relationships.

Supports. Initially, Mr. Raju could not identify family or friends for support. Mr. Raju had few civilian friends. He associated with fellow veterans, despite college enrollment and campus activities. His sole support was his female cousin, to whom he spoke regularly. She visited him at least twice monthly and sometimes weekly. He received financial support from family despite his emotional estrangement, an increasing focus of our therapy. As discharge became imminent, his cousin’s mother agreed to shelter him until he found independent housing.

Levels of functioning. Mr. Raju’s escalating substance use resulted in college expulsion. He isolated himself at home, not bathing for up to a week unless his cousin visited or he needed groceries. His family felt that substance use represented a character flaw, as when he shouted at them during reunions.
Cultural elements of the relationship between the individual and clinician

Mr. Raju frequently tested boundaries of the clinical relationship. At first, he asked about my ancestry, language fluency, and migration history, assuming I was born in India and talked about him wanting me to call him socially after discharge. Once in group therapy, he asked a question in Hindi, presuming we shared this language. I interpreted these behaviors as a desire for relatedness. He begrudgingly accepted that therapy would best work focused on him rather than me. In turn, I reflected on the distance from patients encouraged throughout medical training (Davis-Floyd & St. John, 1998; Good & Good, 1993; Hafferty, 1998). This distance is even wider in India, so I was shocked at his personal inquiries.

Alternatively, he may have identified with my social history. From my name, he surmised my ethnicity. From ritual threads around my wrist, he guessed my religion. He may have projected his sentiment of being the unit’s only Indian patient with an observation that I was the only Indian staff physician. Finally, his medical training and work as a health officer may have raised a professional identification. Most staff thought we shared the same culture, leading to my assignment as his clinician. In contrast, I saw our differences: his veteran status, different subethnicity, education, and substance use. I wondered about his use of expletives, especially since he was a former medical student and military officer. I allowed that his suffering might violate normal clinical etiquette or that chronic substance use might impede executive functioning.

Conversations with previous clinicians indicated the context of Mr. Raju’s history. In the ER with Caucasians, he referred to himself as an “Indian.” In the inpatient unit with Asian Americans, he referred to himself as “Indian American.” Only with me did he refer to himself as “a brown man in a White man’s world.” We analyzed his transferential identification as a desire for social integration. Through motivational interviewing, we worked through ambivalences around substance use treatment to schedule weekly group sessions. Consequently, an examination of our ethno-cultural transferences uncovered deeper conflicts that might have gone undressed (Comas-Díaz & Jacobsen, 1991).

Overall cultural assessment for diagnosis and care

Mr. Raju’s case demonstrates his intersubjective responses to clinicians. His cultural identity shifted until he realized that the group to which he most belonged, and with which he experienced his greatest disappointment, was the military. He firmly attributed his symptoms to deployment. Despite our similarities, I understood his suffering distantly, since his transitions between both countries and military experience introduced significant differences. Ultimately, his ability to tolerate boundaries and distinguish our relationship from friendship positioned him to discover friends and family.
A formal CF allowed personal designations to surface. First, rather than an ethnic classification (“Indian” or “Indian American”), the CF elicited migration and military history as major factors of identity. Second, the social history did not disclose illness causation, help seeking, and social supports valuable for treatment. Third, the CF yielded clinician-dependent information modified over time.

Furthermore, the CF streamlined his final diagnoses. Mr. Raju may have minimized the inheritability of alcoholism, since many Indians, in my experience, regard addictions as character defects, not mental disorders. He may have resisted exploring substance use if he perceived me as religiously orthodox. My observations from our daily interactions also eliminated any Axis II diagnoses. He did not meet criteria for schizoid or schizotypal disorders because he sought close relationships, enjoyed social activities, appeared emotionally responsive to criticism and praise, did not experience psychotic symptoms when sober, and was affectively engaged. Behaviors such as choosing solitary activities, avoiding sexual relationships, and lacking confidants were better explained by his social liminality. Also, his odd demeanor and speech, which had raised the possibility of schizotypal disorder, were similarly explainable, especially through chronic substance use. In addition, his desire to “live in the woods to be with God” may have reflected a cultural defense against incomplete socialization. His position in the United States and the Army had left him with few social supports and he became an outsider, quite literally to India and figuratively within American society, without a caste or religious community that would contribute to a strong group identity in India. Hinduism (Olivelle, 1981) and Islam (Ewing, 1997) in South Asia have evolved mechanisms such as social renunciation in the name of religion for individuals at the margins of society. In conjunction with other clinical data, this explanation made most sense, especially since his self-reference as a veteran may have been the only one available to him.

Finally, the CF eased discharge planning. As social relatedness became an issue, he agreed to attend a community reintegration program that met several times weekly for 4 months. This program provided social workers, occupational therapists, and art therapists for psychosocial management. Despite initial resistance, he also agreed to AA/NA meetings daily to maintain sobriety for housing eligibility. Finally, he agreed to quarterly psychiatric appointments. Therefore, we organized care based on his priorities.

My CF fused several approaches. Initially, I prepared by reading the notes of previous clinicians. I then embedded CF sections within the general assessment to preserve the spontaneity and flow of the interview. During intake, I incorporated questions about cultural identity in the general patient identification (“How do you like to be addressed? Please tell me about where you’re from. What languages are you comfortable with?”). When he mentioned that he was Indian and American, I asked, “How do you stay in touch with your Indian culture? How you see yourself as an American?” I asked about cultural explanations during the history of present illness (“Why do you think this is happening to you? Why now? What is it caused by? Do you know anyone else with this? Have you seen anyone for this? Do
you have thoughts about treatment?’’). I included questions about cultural factors related to psychological environment and levels of functioning in the social history (‘‘What stressful situations are you experiencing? Is this common for people you associate with? How do your family and friends view this? Please list the people you turn to for support. Can I call them? How do you cope with problems? How are your current problems affecting your life?’’). I noted cultural elements of the patient–clinician relationship during the mental status examination. Finally, I appended the cultural assessment to the biopsychosocial formulation.

This approach differs from separating the CF from the general assessment. It saved time and supplied me with essential cultural information, adding approximately 15 minutes to the intake. Nonetheless, his cultural identity, meaning and severity of symptoms, cultural factors around psychosocial supports and level of functioning, and cultural elements of the clinical relationship gradually changed. For example, his shift from an ethnic to a military identification clarified symptom meanings, and social relatedness became central to our work. Scrutiny of his daily life magnified supports and functioning absent in the first interview. Over time, he adjusted comfortably to clinical interactions. These changes imply that a single CF would have been insufficient without updates to reflect his shifting experience. Fortunately, I could spend 15 minutes every weekday over 4 weeks to interview him, but this ongoing reassessment is not available in many clinical settings. Moreover, the information we exchanged differed from that obtained by other clinicians, pointing to the intersubjective nature of the clinical encounter.

Hybridity and intersubjectivity in the clinical case

Recall Bhabha’s (2006) earlier assertion that individuals inhabit multiple subject positions simultaneously. In expressing cultural difference, which subjectivity takes precedence? Mr. Raju’s case challenges how mental health professionals conceptualize culture. As a man, Indian, American, veteran, and health professional, among other subjectivities, Mr. Raju exemplifies the hybridized identity. Rather than reify any single trait, we conducted literature reviews to compare his symptoms with group norms.

For example, Mr. Raju recurrently referred to himself as a veteran. Indeed, he fit the cohort of individuals with two deployments to Iraq who develop PTSD more often than those deployed once (Reger, Gahm, Swanson, & Duma, 2009). Soldiers encounter unique stressors such as exposure to trauma, deployment length, a hostile homecoming, and the stigma of psychiatric treatment in the military (Greenburg, Langston, & Gould, 2007). Nineteen percent of Iraqi veterans report mental health problems (Hoge, Aukterlonie, & Milliken, 2006). Of health care workers like Mr. Raju, 5% and 9% develop depression and PTSD, after deployment to Iraq and Afghanistan respectively (Kolkow, Spira, Morse, & Griege, 2007). Compared to the mid-1980s, alcohol use has increased among active soldiers, in part in response to more frequent advertisements in military
periodicals and cheaper prices at military stores (Bray & Hourani, 2007), which was a factor in Mr. Raju’s decision to drink heavily.

His veteran status also shaped his views on disease causation. No medical ethnographies of veterans in Iraq and Afghanistan yet exist, but a close analogy is Gulf War syndrome (GWS), whose existence has been both postulated (Haley, Kurt, & Hom, 1997) and denied (Ismail et al., 1999). Approximately 17% of British Gulf War veterans believed they had GWS, and this was linked to knowing others with GWS and having received vaccinations against chemical and biological warfare (Chalder et al., 2001). Many veterans traced the cause of diverse symptoms to the Gulf War, pitting them against a biomedical establishment that searched for common symptom clusters rather than common exposures (Kilshaw, 2009).

Another hybrid identity is Mr. Raju’s position between Indian and American cultures. His use of expletives signified his acculturation. As taboo slang conveying offensive force (Fairman, 2007), the phrase “I’m really fucked up” served to convey the enormity of his distress. Despite being destigmatized in the past two decades (Sheidlower, 2009), the word would be too offensive in India for use in clinical encounters. Also, his behaviors as an agnostic Hindu did not typify Hindu Indian immigrants to the United States. He did not conflate race and religion like most second-generation Hindu Indian youth (Kurien, 2005), nor did he attend congregations to prevent cultural and community loss (Kurien, 1998). Perhaps Mr. Raju’s membership in many cultural groups prevented a fuller integration within American society.

His reluctance to seek care was consistent with several aspects of his identity. Less than half of veterans from Iraq or Afghanistan seek professional psychiatric help because of stigma (Hoge et al., 2004) or concerns about confidentiality (Milliken, Auchterlonie, & Hoge, 2007). Similarly, stigma afflicts Indians with mental illness. Indians may present with somatic rather than depressive symptoms due to cultural acceptance (Raguram, Weiss, Channabasavanna, & Devins, 1996). In this respect, his ethnic and military identities may have dissuaded earlier psychiatric care.

Finally, his levels of social support highlight hybrid identities. Indian Americans are often sexually conservative (Fisher, Bowman, & Thomas, 2003), even though sexual attitudes are changing in India, with a third of male respondents in Delhi claiming to have had premarital sex (Jaya & Hindin, 2009). Mr. Raju might be caught between opposing sexual attitudes. Furthermore, veterans from Iraq and Afghanistan with mental illness struggle with families after discharge (Sayers, Farrow, Ross, & Oslin, 2009) with symptoms of alienation, low self-esteem, and resentment at having to meet familial obligations (Hutchinson & Banks-Williams, 2006). Mr. Raju acknowledged feeling close to only one female cousin. Research on Indian American families is limited, but data from India suggest that extended relatives often influence decisions, particularly of youth (Khatri, 1975). Kinship ties remain strong despite spatial distance (Ramu, 1972). With Mr. Raju, an ethnic tendency toward familial connectedness may have offset a military trend against family integration.
Hybridity may partly explain information variation based on clinical intersubjectivity. Hybridity holds that the fusion of disparate cultural references forms a new subjectivity, whereas intersubjectivity suggests that a psychological field emerges from the subjectivities of patient and clinician. Cultural information may represent how individuals intersubjectively negotiate the psychological field formed from cultural identities presented to each other. Mr. Raju’s Caucasian physicians, who perhaps saw him as foreign, labeled his difference as “Indian.” His Asian American physicians, by contrast, drew upon their own hybridized identities to label him “Indian American.” By working through our hybrid transfers, Mr. Raju and I eventually reached his chosen identity as a veteran. This does not mean that other clinicians were insensitive; rather, our individual demographics possibly constructed a safer psychological field through which he could investigate meanings salient for him.

Discussion: New models for clinical interaction

Mr. Raju’s case exhibits the faulty reductionism of recording a superficial identity available to the clinician in the first encounter without contemplating the myriad subject positions and their relative importance in the lives of our patients. Mr. Raju’s intermediary positions between Indian and American, civilian and soldier, destabilize older notions of identity around race or ethnicity. Rather than a solitary affiliation, Mr. Raju—like all of us—occupies a hybrid space that uniquely fuses the many groups from which he draws meanings. Hybridity assumes that individuals belong to numerous cultural groups. This recognition frees the clinician from the burden of selecting, or imposing, a singular identity on the patient who instead possesses the agency to articulate cultural differences. Therefore, the clinician’s task is to determine how culture influences illness experience, including the patient–physician relationship. Although older research examined cultural differences in this relationship (Bot, 1990; Fischer, 1971; Holmes, 1992, 1999), current theorists attend to how culture frames the self, other, and belief systems during therapy (Bonovitz, 2005). Culture also shapes metafactors such as taboos, language, and professional expectations (Gerson, 2004). As immigration and globalization permit people to transcend geography and acquire hybridized influences, clinicians must recognize that descriptions of culture based simply on race or ethnicity may prove inadequate.

Mr. Raju’s case also provokes questions around the changing nature of clinical information based on intersubjectivity. Mental health professionals are often taught that the mental status examination represents the objective dimension of a clinical assessment. The ways in which patients and clinicians view each other may influence the direction of an interview and the data elicited. The informal cultural designations of Mr. Raju’s previous clinicians illustrate this point, as he was portrayed as an “Indian” or an “Indian American” depending on the evaluator. Predetermined designations of clinicians may, in turn, affect such dimensions as mood, affect, thought process and content, insight and judgment in the mental
status examination. Whereas psychodynamic theory previously restricted transfer-
ence and culture to individuals, intersubjectivity locates meanings within patient
worlds rather assuming that meanings are mere patient projections (Yi, 1998).
Social and cultural knowledge shapes narrative (Garro, 1994). Life histories
evolve with others, reflecting a specific moment, not a static social reality
(Crapanzano, 1977, 1984). Private narratives also evolve with others when audi-
ences are imagined (Groleau, Young, & Kirmayer, 2006). Unlike written texts,
medical narratives cast patient and physician simultaneously as author and audi-
ence, altering the rules of discourse (Aggarwal, 2007). The patient’s perception of
physician receptiveness through verbal and nonverbal cues further influences the
coconstruction of illness narratives (Brody, 2002).

Mr. Raju’s case shows how cultural information can change based on clinici-
an. Informal cultural designations rested upon a viewpoint of him as foreigner
or naturalized immigrant, a sense confirmed by Mr. Raju as he offered various
identities. The formal CF, in contrast, initiated a richer conversation. By allow-
ing a narrative style that encourages patients to give voice to their subjective
understandings of self and illness, Mr. Raju could change his designations until
he found one that provided him the most meaning with clinical significance. For
example, his cultural identity and the elements of our relationship transformed
over time, rendering new insights beyond the initial CF. Other categories, such
as cultural explanations of illness and psychosocial supports, could also change,
for example, if patients feel varying levels of stigma during the interview. The
fact that the clinical process can change based on the identities of clinician and
patient shows how hybridity and intersubjectivity impact on the patient’s
history.

Despite a growing literature on the cultural formulation, cultural psychiatrists
have yet to contend with the possibility that all CF dimensions change with the
interviewer with resultant effects on diagnosis and treatment. If all domains of
the CF can vary based on the clinical relationship, how should clinicians implement
the CF throughout multiple levels of care? Since transference and countertransfer-
ence fluctuate among clinicians for the same patient (Good, Herrera, Good, &
Cooper, 1982), which clinician should conduct the CF? The outpatient clinician
who knows the patient intimately? The admitting clinician who initiates treatment,
but interviews the patient in his or her least organized state? The discharging cli-
nician who channels resources to ease social transition and follow-up? Should all
clinicians perform separate formulations to compare which information stays con-
served and salient for the patient? Work thus far has catalogued a single clinician’s
CF with a patient. This paper suggests that studies of CF variations among clini-
cians for a single patient could supplement current research. Such studies could
occur in academic centers, insurance networks, and other systems in which a
patient travels through diverse settings. Additionally, research can illuminate
how the CF changes with the patient and clinician over time, an endeavor that
could be easily accomplished with long-term patients. This may help clarify the
intersubjective extent of the CF.
Finally, preparing a formal CF with a clear focus on hybridity required an ongoing literature review to provide social norms for Mr. Raju’s multiple references. Hybridity compels clinicians to recognize the individuality of patients even as they derive meanings through groups. In our case, Mr. Raju could have been exoticized as an uncommon Indian American veteran, leading to more systemic marginalization that might have worsened his sense of isolation. Instead, we ascertained which groups held the most meaning for him and situated him accordingly. In this way, a broad literature review spanning psychiatry, anthropology, and religion revealed areas for active clinical intervention.

In conclusion, notions of hybridity and intersubjectivity allow us to recognize how patients and clinicians inhabit many identities that impact on the exchange of information. The predicament for clinicians is how to organize care when the patient–clinician interaction can be so variable. A CF attentive to these dynamics might better operationalize cultural data clinically to become a tool for all clinicians and not just cultural psychiatrists.

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**Note**

1. According to India’s 2001 census, Telugu is a Dravidian language spoken by over 70 million people in South India, mostly in the province of Andhra Pradesh (Government of India, Ministry of Home Affairs, 2001).

**References**


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