AMERICAN PSYCHOLOGICAL ASSOCIATION
THEORETICAL & PHILOSOPHICAL PSYCHOLOGY
Journal of Theoretical and Philosophical Psychology

In the public domain
ISSN: 1068-8471
https://doi.org/10.1037/teo0000230

Cultural Pragmatism: In Search of Alternative Thinking About Cultural Competence in Mental Health

Jonathan Yahalom and Alison B. Hamilton

U.S. Department of Veterans Affairs, West Los Angeles, California, United States

Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, University of California, Los Angeles

Researchers have tended to approach cultural competence through two primary models: acquisition of culturally tailored skills and orientation to cultural process. While each model plays an important, complementary role in cultural competence, both can be limited in conceptualizing and responding to cultural variations of distress. This article draws on research in multicultural psychology, psychological anthropology, and pragmatic philosophy to introduce cultural pragmatism, an alternative orientation to cultural competence that reconceptualizes what it means to hold something to be true in the mental health fields. This article first draws on research in multicultural psychology and psychological anthropology to identify an important limitation regarding how truth is understood in contemporary cultural competence models, and how this limitation can impact culturally competent care. Following this, the article considers philosophical pragmatism as an alternative and introduces a preliminary model for practicing cultural pragmatism in clinical settings. As a whole, this article makes two interrelated arguments: first, that a better articulated theory of truth is needed to achieve the goals of cultural competence, and second, that cultural pragmatism can help resolve the limitation that cultural competence approaches currently exhibit.

Public Significance Statement

This article discusses theory that underlies cultural competence in the field of psychology. By drawing on research from varying research disciplines, this article reveals limitations in how cultural competence is understood and contributes alternative theory to improve clinical practice.

Keywords: cultural competence, psychological anthropology, multicultural psychology, epistemology, philosophy

Jonathan Yahalom https://orcid.org/0000-0002-5444-1878

The authors would like to thank Elizabeth Fein for helpful comments and suggestions for improving an earlier version of this article.

A version of this article was presented by the first author in 2021 at the Annual Meeting of the American Anthropological Association. Jonathan Yahalom expresses gratitude to Barbara Wettstein, Carissa Klevens-Thomas, Joanna Rowles, and Barry Guze for support in conducting this research, and Julia Deixler for editorial feedback. Alison B. Hamilton's research is supported by U.S. Department of Veterans Affairs Health Services Research and Development Research Career Scientist Award (RCS 21-135). The views expressed are those of the authors and do not necessarily represent the views or policies of the institutions in which they serve, including the Department of Veterans Affairs or the United States Government. The authors have no conflicts of interest to disclose.

Correspondence concerning this article should be addressed to Jonathan Yahalom, U.S. Department of Veterans Affairs, Building 401, 11301 Wilshire Boulevard, West Los Angeles, CA 90073, United States. Email: yahalomphd@gmail.com or jyahalom@mednet.ucla.edu

Mental health clinicians are experts in human psychology but, when it comes to matters of culture, assumptions about the authority of clinical knowledge can hinder meeting patient needs.[1]

Consider the following cases. A Salvadorian refugee reporting tearfulness for the past 3 months contests being diagnosed with clinical depression; she states that her wanting to die by suicide is her children's best chance to remain in their host country. A military veteran becomes irate when a clinician uses the word "rape" to account for his posttraumatic stress disorder symptoms; he argues that men get assaulted, not raped. A family caregiver suffers from loneliness as she cares for an aggressive husband recently diagnosed with Alzheimer's disease; in her rural Oaxacan community, dementia is stigmatized and viewed as the consequence of family neglect and social change. In each of these actual cases, clinicians carry certain understandings about reality that are taken to supersede patient perspective: that depression is distorting one's perception of available options; that the word "rape" does, in fact, apply to men and women; and that Alzheimer's is a neurological condition that occurs regardless of social change. Yet in each of these cases, asserting what is true from a clinical perspective carries risks. Clinical knowledge may provide different considerations for patients to grow by, yet its assertion could equally overlook a separate, but related, set of truths—cultural truths—that constitute another person's experience.

Patients regularly hold their own perspectives of illness that differ from clinical ones. While such differences might be a routine occurrence in clinical practice, more attention could be directed toward how varying cultural perspectives complicate—but potentially enhance—clinical efforts to provide culturally appropriate care. In many ways, the importance of such perspectives has already been addressed in research on cultural competence, broadly defined here as a clinician's effectiveness in working with people of diverse backgrounds, including their consideration of and responsiveness to culture, to meet patients' needs, and to maximize their development (see D. W. Sue, 2001). In the field of psychology, for at least the past 2 decades, research on the topic of cultural competence has been considered foundational to address gaps in knowledge about bias (Merino et al., 2018), cultural groups in clinical research (Nelson, 2002; U.S. Surgeon General, 2001), as well as differences in help-seeking attitudes and behaviors (Kam et al., 2019). In clinical practice, improvements in cultural competence are thought to improve therapeutic alliance (Anderson et al., 2019), resolve disparities in mental health utilization and service retention (Chen & Rizzo, 2010), and increase sensitivity for cultural differences regarding treatment expectations and preferences (Flynn et al., 2020; S. Sue, 1998), to name but a few areas relevant to practice.

Researchers have tended to approach cultural competence through two primary models: (a) acquisition of culturally tailored skills and (b) orientation to cultural process (S. Sue et al., 2009). A skills model views cultural competence as the development of cultural awareness, specific skills, and techniques to be used with culturally diverse populations. In this article, a skills-based approach refers to both a clinician's ability to provide therapies that are adapted for specific cultural groups (e.g., Borrelli et al., 2010), as well as acquisition of knowledge about cultural groups to inform culturally appropriate care (e.g., D. W. Sue, 1990). By contrast, a cultural process model places emphasis on the dynamic (or process) that occurs between patient and provider, and how the patient identifies with, responds to, embodies, and experiences their cultural worldview when receiving clinical care. Examples include an emphasis on cultural humility (Foronda, 2020; Tervalon & Murray-García, 1998), shifting cultural lenses between provider and patient (Lakes et al., 2006; Lopez, 1997; Lopez et al., 2020), and emphasizing the provider's orientation to how cultural dynamics between patient and provider interacts to cocreate a relational experience (Davis & DeBlaere et al., 2018). Cultural process models attend to the dynamic fluidity, intersectionality,

[1] In this article, we employ the term "patient" to refer to the individual seeking mental health treatment. The word "patient" has its origin in the Latin "pati" — to undergo, suffer, or bear—and is problematic because it implies an asymmetrical power dynamic and conveys passivity about the person receiving care (Shevell, 2009). Yet the term is commonly used in clinical settings. For this reason, as opposed to using an alternative term, we employ "patient" with the intention that the arguments made in this article specifically be applied in clinical care which today is influenced by and intersects with medical practice. We aim to disrupt the assumptions made about *people* as patients whose meaningful, agentive, and dignified lives can be overlooked in clinical settings and to ultimately highlight the person within the term patient.

and lived experience of cultural worldviews, and they complement the skills-based model of cultural competence.

Both skills-based and process models play an important role in cultural competence. Yet even when applied together, they can be limited in responding to real-life clinical encounters like the vignettes presented above. Neither model sufficiently addresses the underlying issue of how to appreciate and uphold a cultural understanding of distress that differs from clinical knowledge. That is because it is difficult for providers to practice cultural competence when it is assumed there is an objective, culture-free perspective of psychological distress. This issue is what anthropologist B. Good (1994) termed the "epistemological ambivalence" inherent not just to mental health but to the broader clinical sphere. "The question," writes Good, "is how we situate our analyses of cultural representations of illness [that is to say, patients' own understanding of illness] … in relation to the truth claims of biomedicine" (p. 28). Good is referring to an ambivalence about how clinicians can claim to respect or attend to the things patients hold to be true, while maintaining the scientific truths established in their own discipline. One seems to negate the other.

This article introduces a novel orientation to cultural competence, one that attempts to resolve implicit epistemological ambivalence within clinical care. Drawing on research in multicultural psychology, psychological anthropology, and pragmatic philosophy, this article presents the notion of cultural pragmatism to reconceptualize what it means to hold something to be true in the mental health fields and to consider why clarification about truth—and cultural factors that shape truth—is important to clinical care. In what follows, this article first identifies specific assumptions and a limitation about truth in skills-based and process-oriented models of cultural competence with reference to anthropological and multicultural research. Following this, the article considers the philosophy of pragmatism as an alternative perspective about what it means to hold something to be true and reflects on the relevance of cultural pragmatism for establishing an epistemological groundwork for cultural competence. Last, the article introduces a preliminary model for practicing cultural pragmatism in the clinic. As a whole, this article makes two interrelated arguments: first, that a better articulated theory of truth is needed to achieve the goals of cultural competence, and second, that cultural pragmatism can help resolve the limitation that cultural competence models currently exhibit.

Assumptions About Truth in the Clinic: An Interdisciplinary Perspective

Clinical knowledge, including knowledge learned about cultural groups, tends to be viewed as being tested and true. Being informed by empirical inquiry, clinical practice is often seen as "a culture of no culture," an objective and value-free application of scientific facts (Taylor, 2003). Such a perspective often leads to distinguishing between clinical truths (established by empirical science) and cultural truths that comprise one's lived experience (Carpenter-Song et al., 2007; Duncan, 2018). The problem, as highlighted in this article's opening vignettes, is that this perspective of truth can diminish attentiveness to cultural dimensions of illness: clinical knowledge risks being set at odds with cultural experience.

This accounts for why some researchers in psychology observe that mental health's two mandates—to remain truth-seeking and to practice cultural competence—are "on the road to collision" (La Roche & Christopher, 2008; see also Hall, 2001; Kirmayer, 2005). Whereas some recent, more narrow understandings of evidence-based practice aim to provide treatment based on the best available research, cultural competence advocates argue for the importance of attending to human diversity.[2] As Gone (2015) wrote,

> The challenge is to take cultural variety very seriously … without either requiring a complete abandonment of clinical expertise (a trivialization of professional knowledge) or embracing merely superficial alterations in professional conventions toward otherwise familiar therapeutic objectives (a trivialization of cultural difference). (p. 141)

This tension between adherence to truth and cultural competence can be noted in both models

[2] The American Psychological Association, Presidential Task Force on Evidence-Based Practice (2006) defines "evidence-based practice" as consisting of three parts: (a) scientific evidence (both quantitative and qualitative), (b) clinical judgment, and (c) patient values. While this original definition is inclusive of clinical experience and cultural diversity, the latter two components tend to be overlooked in common understandings of evidence-based practice. This is further discussed in the Concluding Remarks section of this article.

of cultural competence. First, with a skills-based model, in emphasizing clinical skills or expertise, there is risk of overlooking cultural variety. At first glance, there is no difference between gaining clinical expertise about culture—to learn about cultural factors in the prevalence, diagnosis, and treatment of a given illness, for example—and expertise about evidence-based approaches to care. In adaptations of therapies to meet cultural needs (which in this article are taken as extensions of a skills-based approach to competence), service delivery and therapeutic process are modified to better align interventions with patient cultural experience (e.g., Bernal et al., 1995). Clinicians draw upon their expertise—including expertise about working with a given cultural group—and are informed by empirically supported research (Lilienfeld et al., 2014; S. Sue et al., 2009). Truth in this sense refers to what is empirically tested and validated, and what any informed researcher would agree best explains clinical phenomena, including empirically based knowledge about cultural groups.

It is vital to gain knowledge about culture to improve treatment efficacy across cultural groups and, indeed, research shows that culturally focused treatments are mostly efficacious (Huey et al., 2014). Moreover, when culture is overlooked in treatment, other studies indicate that therapy can be more successful among White populations compared to culturally diverse populations (Drinane et al., 2016; Imel et al., 2011; Owen et al., 2012) that patients who identify as cultural minorities commonly experience microaggressions from their therapists (Owen et al., 2014), and minority populations are diagnosed with more severe forms of mental illness compared to White populations (Londono Tobon et al., 2021). These are just a few instances of why attending to cultural differences is critical to competent clinical care and the overall need for a skills-based approach to cultural competence.

Despite the importance of attending to culture in these terms, many anthropologists and a growing sector of psychologists have issued two broad critiques about a skills-based approach. First, they have objected to oversimplification of cultural categories. Conventional ways of categorizing people according to ethnic, racial, or cultural lines are no longer viable and perhaps never were: previous approaches to studying culture as composed of five major ethnoracial categories (American Indian, Asian, Black or African American, Pacific Islander, or White) do little to capture the nuances of cultural identity (Kirmayer, 2013). Many contemporary psychologists also warn against relying on cultural stereotypes and related "ethnic glossing" that maintain a false view of homogeneity within cultural groups; there exists significant diversity within cultures, and it is insufficient to simply rely on cultural knowledge to understand the uniqueness of a given patient (American Psychological Association [APA], 2017; S. Sue, 1998; Trimble & Dickson, 2005).[3] Moreover, there is inherent intersectionality (APA, 2017; see also: Cho et al., 2013) or "hyperdiversity" (Hannah, 2011) that involves the interconnected and multiply-occurring cultural categories that a single individual can experience as definitive of their culture, bringing together experiences such as: race, class, and gender, as well as other social experiences like immigration status, linguistic group, and national origin. For this reason, some anthropologists claim that the inherent complexity of culture "shatters" even the capacity to talk usefully about culture (M. J. D. Good & Hannah, 2015) and that there are certain "epistemic limits" about studies on culture and their usefulness to clinical application (Kirmayer, 2013; see also: Patterson, 2004; Thomas & Weinrach, 2004).

In this light, many anthropologists argue it is mistaken to assume studies on culture will be predictive because our implicit definition of culture is distorting: culture is not static or something a person upholds, "has," or "is." Instead, anthropologists suggest culture is more accurately understood as a *dynamic process* that refers to peoples' shared ways of understanding, interacting, and meaning-making in the world (see Geertz, 1973; Guarnaccia & Rodriguez, 1996; Kleinman & Benson, 2006; Llerena-Quinn, 2013; Santos et al., 2021). For this reason, it is argued that attempting to study culture through

[3] For example, in the first author's previous research in Oaxaca, Mexico, the terms *Mexican, Oaxacan,* and *Zapotec* (a local indigenous group) meant very little to local participants. Identity was not based on broad political or ethnic categories but rather defined by participants' specific communities and distinguished by community-specific languages, customs, foods, and dress (see Yahalom, 2019b). While other cultural settings may differ in this regard, the same point cautioning against overgeneralizations or reliance on cultural categories remains: individuals have their own distinct understandings of culture, belonging, and identity, which is why broad categorizations can often overlook cultural experience.

research on cultural categories is limited and there are growing calls to discontinue using the term "cultural competence" in lieu of alternative descriptions practice such as cultural humility (Tervalon & Murray-García, 1998).

A second critique against relying on a skills-based approach involves the inherent power relations that arise whenever culture is invoked. In an influential article, Abu-Lughod (1996) emphasized the nature of culture as intersubjective and, for this reason, laden with power: Any way one talks about culture, it is based upon the positionality of the researcher or clinician, and the other person being studied or treated. She wrote that conclusions having to do with culture "enforce separations that inevitably carry a sense of hierarchy" (p. 138). For this reason, Abu-Lughod encouraged moving beyond an understanding of culture that we might initially view as tentative and based on what Clifford and Marcus (1986/2010) termed "partial truths" that never capture the full complexity of cultural experience, and instead suggested that we might also appreciate that any data purported to be about culture is also a "positioned truth," based on specific power imbalances (p. 142; a similar point interpreted in Levinas, 1969/1992). This critique highlights how gaining information about culture is inescapably steeped in power dynamics that reinstate distance between researcher and researched, and, for the same reason, provider and patient.

A process-oriented approach to cultural competence attempts to resolve these critiques by shifting focus from the cultural (or group) level of experience toward the individual level (e.g., Davis & DeBlaere et al., 2018; Lopez, 1997; Tervalon & Murray-García, 1998). This approach emphasizes the interpersonal dynamics that constitute treatment between patient and provider, emphasizes culture as dynamic process and, in doing so, attends to cultural variety and discourages "ethnic glossing" or stereotyping that would overlook the person behind a cultural category (Trimble & Dickson, 2005; S. Sue, 1998). From this approach, gaining cultural knowledge is important insofar as it provides information about the circumstances of a person's life, broader social horizons, and underlying values. Yet accumulation of cultural knowledge is not the goal in itself; rather, it is appreciation of individuals as cultural beings, varyingly identifying with their cultural backgrounds, and dynamically adapting to the surrounding world. From this model, cultural competence is viewed as distinct from other forms of clinical competence: it is not the acquisition and mastery of knowledge about cultural groups (in comparison to mastery of other clinical facts) but rather a sensibility about what informs a person's worldview and a tact in being able to engage with and respond to it (Davis & DeBlaere et al., 2018; Kirmayer, 2012; Yates-Doerr, 2018).

However warranted a process-oriented approach to culture is and however much it supplements a skills-based approach, it risks being understood in conjunction with an assumption about clinical practice that is acultural. There remains an implicit tension, outlined by B. Good's (1994) notion of "epistemological ambivalence," between the truth of a patient's experience and the truth that informs a clinician's work. Whereas in the skills-based model, truth is what is empirically validated (about prevalence, diagnosis, and treatment for given cultural groups, for example), in a process-oriented approach, truth is split. A process-oriented approach would attend to the individual complexity and nuances of cultural experience while simultaneously maintaining that clinical understanding is rooted in scientific objectivity.

For example, the clinically useful "shifting cultural lenses" model suggests that one behavioral indicator of engaging a process-oriented approach is the specific negotiation that occurs between patient and provider in their mutual understanding of illness (Santos et al., 2021, p. 129; see also: Lakes et al., 2006; Lopez, 1997). Negotiation is similarly identified as a component of cultural humility (Tervalon & Murray-García, 1998) and the multicultural orientation framework (Davis & DeBlaere et al., 2018). Yet, negotiation implies the difference between two perspectives that may not be mutually intelligible and do not need to be mutually appreciated. Moreover, through the process of successful negotiation, two parties' needs are met but the resolution of their differences can result in one set of needs superseding the other. The emphasis on negotiation, it seems, implies a fundamental difference between cultural experience and clinical expertise. When patient and provider engage in negotiation, there is risk of viewing clinical suggestions as something patients are expected to comply with and viewing patients who do not comply as being at fault and jeopardizing treatment success. This is a concern given contemporary standards inspired by the recovery

movement that seek to move beyond focusing on patient compliance with clinical advice and toward fostering patient self-determination and agency (Davidson, 2016; Corrigan et al., 2012).

The clinical vignettes at the beginning of this article help further articulate why this epistemological split is significant. One might be tempted to negotiate a new understanding to contest a diagnosis of depression when a patient's symptoms fit with diagnostic criteria, to claim that a veteran is mistaken to claim that men cannot get raped when the definition of this word suggests otherwise, or to suggest that a rural community is misinformed to believe Alzheimer's is caused by social neglect when scientific evidence suggests it is the consequence of neuropathology. In each of these cases, the respective diagnostic, linguistic, and neurological facts would support making these arguments. They are factual, and they adhere to the objectivity of words and evidence as best as we understand them. The problem is that they assert clinical perspective over patient experience and, in doing so, risk foreclosing clinical dialogue and therapeutic alliance. Hence, insofar as models of cultural competence implicitly appraise clinical knowledge as more factual than cultural experience, they lose the ability to resolve these common clinical dilemmas on an epistemological level.

Philosophy of Science, Philosophical Pragmatism, and the Relevance of Pragmatism to Clinical Practice

While both skills-based and process-oriented models are useful for meeting the goals of cultural competence, there remains an implicit discrepancy (or "epistemological ambivalence") between how clinicians attend to cultural variation compared to how they apply clinical knowledge. Left unresolved, this discrepancy risks having one perspective asserted over another and missing the target of culturally competent care. What is needed is a way to resolve the discrepancy between the way we think about clinical knowledge and cultural experience, and to ultimately appreciate each on their own terms.

At least retrospectively, arguments from the philosophy of science already began to raise awareness about the problem of differentiating truth from culture. In his illuminating article, "Is Psychological Science A-Cultural?" Gone (2011) reviewed how, during the first half of the century, science was understood via positivism, a philosophical position that alleged that scientific knowledge was based on empirical verifiability. So, for example, we know depression increases risk of suicide, childhood trauma impacts psychological development, and eating disorders imperil physical well-being. These findings have been studied and tested, and we commonly believe something to be true because scientific studies have demonstrated them as such. Yet while this sensibility of acquiring the truth continues to dominate in clinical spheres, Gone reminded us that the idea of knowledge being "proven" was challenged already during the mid-20th century: Popper (1959) argued that a scientific finding is never actually verified but better understood as a tentative hypothesis that has not yet been falsified; Kuhn (1962) observed that scientific progress is rarely a sequential accumulation of facts but often a result of rupturing paradigm shifts. Both arguments critiqued the underlying notion that the information we have gained from science is objective and transcendent of cultural variation, and instead argued that scientific findings are better conceived as cultural products, the best available information we have at a given time. In this vein, Gone argued that science, albeit uniquely contributing to knowledge by applying rational thinking to empirical evidence, "is never adopted or deployed outside of culturally constituted interests, objectives, and motivations" (pp. 238–239). For that reason, he concluded, psychology is inherently cultural. In the clinical fields, then, it would not be feasible to disentangle what is cultural from what is empirical.

What we come to know through scientific inquiry about culture is vital to clinical practice (Kirmayer & Jarvis, 2019): empirical findings about improving diagnosis across cultural groups (Londono Tobon et al., 2021), adapting treatment for a given cultural population (Borrelli et al., 2010), and recognizing social and structural determinants of distress (Gómez-Carrillo & Kirmayer, 202; Metzl & Hansen, 2014) are just a few examples of why empirically attending to culture enhances clinical effectiveness. But there is a difference between saying that "culture is part of the social world and available to study," an obvious point except for hard-lined skeptics who might question it, and another statement that "the truth about culture is part of the social world for us to definitively know." The latter point suggests

that, with enough information, what we come to understand about culture will correspond to the objective, reality of the cultural world (see Rorty, 1989, p. 4). Yet insofar as we appreciate anthropological perspectives about culture as dynamic process, culture cannot be viewed as an objective and static object.

Pragmatism is a philosophical approach that provides epistemological justification for this sensibility and ultimately helps secure both cultural experience and clinical knowledge on equal footing. Like the philosophers of science above, the pragmatists hold that truth is not something objective, waiting to be verified, and agreed upon by all perceptive parties—something that would purportedly transcend cultural variation—but rather see truth as constituted within culture. Yet the pragmatists go further by redefining what we mean when we claim that something is true, and it is this redefinition that helps resolve the implicit discrepancy between clinical knowledge and cultural experience. Simply put, the pragmatists hold that truth is a statement about usefulness. "Truth," to quote pragmatic philosopher James (1907/2000), "is not a stagnant property inherent" to an idea. Rather, "truth *happens* to an idea. It *becomes* true, is *made* true by events" (p. 88)—including, one might add, by cultural events and cultural ways of being.[4]

Claiming that is truth made rather than found is based on a particular way of understanding truth and thinking more generally. Peirce (1877), often credited as the founder of pragmatism, began with an observation that a belief is nothing more than a habit. Peirce argued that once we gain recognition of how our thinking is based on our ways of acting and our habits, we realize that our beliefs about the truth are not objective perspectives of reality—rather, they are simply statements about us, and how we have come to engage with the social and natural world. Putnam (1995) helped further articulate this perspective, stating that pragmatist philosophy makes the basic point that "knowledge of facts presupposes knowledge of values" (p. 14). By this, Putnam argued that our accumulation of facts is based on concrete everyday experience, and that we are only attuned to consider something as a possible fact if it concretely (i.e., "pragmatically") contributes to our previous understanding and dealing with the world.[5]

According to the pragmatists, truth "happens" to an idea because that idea proves to be useful. If we consider the impact of what it commonsensically means to hold something to be true in the clinical sector, we can better recognize the relevance of pragmatism. In the vignettes that opened this article, most clinicians can agree on the diagnostic symptoms of depression, linguistic definitions of sexual trauma, and neurological information we have gained about Alzheimer's. We assume these to be objectively true. But pragmatists allege that maintaining these statements is more an expression of *us*—our experience, our values, and our customs—than the objective reality of the world.[6] So too with other forms of clinical knowledge: Pragmatism encourages viewing evidence-based approaches not as an expression of what is objectively true,

[4] James (1907/2000) famously introduced pragmatism through a hypothetical thought experiment: Imagine a man is circling a tree trying to see a squirrel who continuously escapes being seen. So, asks James, does the man go around the squirrel or not? James introduces pragmatism by answering that there is no final answer—there isn't a metaphysical truth underlying the question—because whichever answer one defends is rooted in its respective practical consequences, the "difference … it would practically make to anyone if this notion rather than that notion were true" (pp. 24–25). The same applies to questions in the clinic. In more contemporary work, White (2009) imagined a case of indigestion, where the patient views indigestion as the cause of having eaten bad food, but a doctor understands indigestion due to underlying ulcers. Similar to James, White concluded that both understandings are true, based on different ways of understanding the world: "We see that they are answering different questions and so both can be speaking truthfully" (pp. 89–90). The pragmatic philosophers can be understood as critiquing the prioritization of one type of truth—a truth that transcends human experience or is objectively waiting to be discovered—because at least when it comes to culture and human experience, there is no way to go beyond experience. Instead, as William James (1907/2000) wrote, "truth is made," rather than found (p. 96; see also: Richardson, 2007; Rorty, 1989). And by this, James argued, what we believe to be true is an expression of how we have come to engage, pragmatically, with the world. Whether we say that the man really *is* going around the squirrel or that the patient *has* indigestion because of an ulcer, both answers say more about us and our particular ways of seeing and interacting with the world than statements about the world's underlying reality.

[5] To echo the writings of Dewey (1998), what we consider to be true "is a knowing how rather than knowing that" (Brandom, 2011, p. 7).

[6] Anthropologists make a similar point in attending to cultural "idioms of distress," defined as popular expressions of illness that express cultural viewpoints. Yet, anthropologists direct attention beyond *what* is different about a given idiom and instead encourage focus on *why* and *how* an idiom is expressive of social adaptive functions (Nichter, 1981, 2022; Yahalom, 2019a).

but rather as expression of what works in a given cultural setting. What clinicians hold to be true is what works in the clinical sector.

To be sure, pragmatism is offering a theory of meaning—of what we *mean* when we say something is true—and is not a theory of truth in itself. But this semantic shift is helpful for clarifying fundamental assumptions about cultural competence in mental health. Pragmatists would warn against clinicians who justify their work through clinical knowledge that is purported to be an objective statement about cultural experience or to claim they have knowledge that transcends cultural variety.[7] As will be described below, this stance helps guard against potential conflict between empirical truths and cultural experience.

Cultural Pragmatism: A Preliminary Model

Cultural pragmatism is a clinical application of the pragmatist approach to truth. It offers clarification and redefinition about what both provider and patient are saying when they hold something to be true and, in doing so, attempts to put both on equal epistemological footing. In essence, cultural pragmatism posits that statements about truth are statements about what is useful for that person: clinicians are justified in maintaining their knowledge because they have observed that what they do works; similarly, patients hold their truths because those truths function in the context of their lived experience. To again invoke the opening vignettes of this article: a migrant who considers suicide but denies that she is depressed *works* for the purpose of securing the well-being of her children, men asserting that they do not get raped *functions* when they feel their masculinity is questioned, and Oaxacans believing Alzheimer's is the result of social change is *adaptive* when their community is threatened by change. Each of these stances contests clinical knowledge but each also functions for people in specific cultural settings.

The pragmatic attitude can be applied to the clinic in specific ways, and what follows aims to broadly and preliminarily outline how pragmatic thinking might be mobilized. The following five steps attempt to concretize what is termed "cultural pragmatism," a sensibility that would allow for integration of both clinical and patient viewpoints in treatment. Of course, these steps are not linear, nor do they mean to suggest specific moments in the clinical encounter. They better represent an attempt to engage research from multicultural psychology, anthropology, and pragmatism to provide approximate measurement for whether that interdisciplinary sensibility is being applied in a clinical setting.

Step 1: Identify What the Patient Holds to Be True About Illness

Cultural pragmatism first asks clinicians to consider what a patient holds to be true. It is easy to overlook patient perspectives by translating different expressions of illness into a framework (biomedical, cognitive, psychodynamic, and so forth) that clinicians prefer to operate within—as an instance of chemical imbalance, inaccurate thinking, repression, and so forth (see Abramowitz, 2010). Yet, translating between illness categories risks committing what Kleinman (1988) terms a "category fallacy," reifying one's own (cultural) understanding of illness onto another's, and potentially overlooking the nuanced differences in local meanings and experiences between the two.

Identifying what the patient holds to be true about illness offers a preliminary guardrail. It also highlights how a patient's understanding about mental illness is not something to be challenged. So, cultural pragmatism begins by putting the patient first, asking exploratory questions such as: "Why do you think you're experiencing the

[7] The point is not to suggest that gaining more information about culture is misguided. Again, empirical inquiry is based on rational thinking and testing, which is why it is different from mere observation (Gone, 2011). In this vein, James staunchly defended the relativism of pragmatism while remaining committed to empiricism. James embraced empiricism with self-professed intensity, calling his version a "radical empiricism" and arguing that to be truly empirical one "must neither admit into [one's] constructions any element that is not directly experienced nor exclude from them any element that is directly experienced" (James, 1912/1976, p. 42; see also Hollan, 2022). James is essentially arguing for a direct engagement with experience, with the lived experience of the here-and-now, and cautioning against abstractions that take away from experience in the guise of theories, models, and broader generalizations. That is why, based on James' conceptualizations, clinicians would do well—indeed they *ought*—to develop a skills-based approach to cultural competence and familiarize themselves with other ways of life and other cultures. Doing so is a way to be in contact with—to have experience of—cross-cultural clinical work. But the pragmatists would caution against what clinicians are liable to do with that information, and specifically, how they might assume that information endows them with a type of generalized skill—or "competence"—simply because they have gained additional knowledge about a given cultural group.

condition that brings you to treatment?" "Why are you seeking treatment now, as opposed to earlier in your life?" or "How do you think I might best be able to address your needs?" Additional guided and useful questions can be found in the *Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition* Cultural Formulation Interview (APA, 2013; Lewis-Fernández et al., 2016). In general, the goal is to recognize that the patient has their own understanding of illness, to convey respect for that point of view, and to invite further discussion of it.

Step 2: Explore the Function of Patient Truth

From the pragmatists, we consider how truth is a statement about what works for a given person. Truth is something that expresses identity, agency, and responsiveness to surrounding contingencies—and not something to convince others about. For this reason, it is important to attend to how different people have different reasons to worry and seek treatment—and how those reasons could be addressed to provide a clinically relevant response.

This involves identifying *why* and *how* maintaining a specific perspective about illness functions. It also involves what is "at stake" for a given individual (Kleinman, 1997), that is, what seems most relevant when confronted with illness, what illness threatens in a person's life, and what constitutes a person's reasons for seeking treatment (see also Lopez, 1997). Identifying function and relevance helps attune clinicians to the fact that different viewpoints about illness are constitutive of cultural diversity and informs why a person might seek and continue to engage with treatment. Moreover, this perspective on truth provides the groundwork for appreciating the variability and intersectionality of cultural experience that is described in anthropological research (e.g., M. J. D. Good & Hannah, 2015; Kirmayer, 2013) and endorsed in contemporary multicultural best practices in psychology (APA, 2017).

Step 3: Discuss the Importance of Patient Concerns (and Draw Upon Relevant Cultural Knowledge)

Cultural pragmatism encourages the use of previous knowledge gained about culture and encourages a skills-based approach to acquiring cultural knowledge, but it attends to patient experience first. After acquiring awareness about what is important for a patient, cultural pragmatism involves discussion between patient and provider about why it matters, both from a patient's and provider's point of view. This primarily involves a mutual recognition of the social parameters that define a patient's life. This is also the point at which clinicians might draw upon their own knowledge of a patient's background and convey understanding of (or at least care for) that worldview. It is useful to turn to previous training in cultural values and orientations (S. Sue et al., 2009), cultural conceptualizations of distress (Lewis-Fernández et al., 2016), as well as structural factors that constitute health disparities (Metzl & Hansen, 2014), to name but a few examples. Each can prove to be helpful in promoting therapeutic dialogue and developing culturally relevant responses—to demonstrate prior awareness and appreciation of a patient's cultural experience—but only to the extent that they resonate with the patient, with what functions, and what is at stake to that person seeking treatment.

Step 4: Collaborate Based Upon Clinical Best Practices

Patients seek help from providers because of their presumed expertise in the field. Yet it is the clinician's responsibility to honor this power dynamic and be cautious against substituting a cross-cultural collaborative strategy for one that purports to be acultural and objective. To this end, clinicians can inform patients about how they, as clinicians, are trained to understand distress, and what they know about how distress is optimally treated. They can discuss evidence-based approaches to recovery. Yet, clinicians can also simultaneously translate their clinical knowledge to relate to the specific concerns of a patient's life. In this way, interventions shift from being presented as acultural toward engaging with the individual dimensions of experience.

When clinical skills and cultural knowledge are viewed pragmatically, providers move from negotiation of treatment strategies to collaboration. Collaboration involves both keeping focused on what matters to a patient and discussing how specific interventions might address those concerns. Drawing on the recovery movement, two

additional mechanisms to promote collaboration involve: (a) aiding the patient (who is recognized as a rational actor) through clinical choices and shared decision-making, as well as (b) addressing environmental forces that are barriers to choice (Corrigan et al., 2012; see also: Metzl & Hansen, 2014).

Step 5: Situate Subsequent Interventions in Patient Language, Including What Is at Stake

In step with viewing cultural competence as a matter of humility (Tervalon & Murray-García, 1998), remaining oriented to relational experience (Davis & DeBlaere et al., 2018), and the importance of shifting cultural lenses between provider and patient (Lakes et al., 2006; Lopez, 1997; Lopez et al., 2020), cultural pragmatism is not representative of a specific moment in clinical work, but a stance about clinical exchange more generally. In this sense, cultural pragmatism represents the ideal of continual openness to patient perspective as well as a commitment to recognize, respond, and adapt to what specifically is at stake to the patient.

For clinicians, drawing upon patient language—appropriately using specific idioms of distress, as well as appealing to specific values and aspirations—is a mechanism to appreciate and remain attuned to cultural experience. This specifically means translating clinical language to the subtleties of patient experience, viewing previous training and clinical knowledge in light of cultural considerations, and continually drawing upon patient language, to the degree that it is indicated, appropriate, and possible. Situating clinical work in patient language represents a type of epistemological anchor to remain grounded in the patient's worldview, and to guard against becoming unmoored in contrasting truths a clinician might hold (for more on pragmatism and language, see Putnam, 1995; Rorty, 1989; Wittgenstein, 1953/2009).

Concluding Remarks

This article has reviewed how cultural competence has commonly been approached through two complementary models: a skills-based model emphasizes the acquisition of culturally tailored skills, whereas a process-oriented model shifts focus from the cultural (or group) level of experience, toward the individual patient, as cultural being. Both models offer significant, complementary approaches to reach the goals of culturally competent care. Yet there remains an underlying, implicit "epistemological ambivalence" (B. Good, 1994) or tension between cultural variety and clinical expertise (Gone, 2015). As such, both models risk prioritizing clinical perspectives of illness over cultural ones.

Cultural pragmatism attempts to resolve this dilemma. Through introducing a nuanced alternative to understanding what it means to say something is true in the clinical fields, this article has argued that an alternative epistemology that appreciates truth as a matter of function guards against the implicit risk of imposing one perspective over another. Cultural pragmatism offers an approach to clinical work that is epistemologically cross-cultural and decentered—and rooted in a view of truth that is at once informed by clinical best practices, while also allowing those practices to be challenged, interrupted, and adapted to the varied dimensions of cultural experience. The components of cultural pragmatism introduced in this article are meant to engage with contemporary research on culture from multicultural psychology, psychological anthropology, and pragmatic philosophy, and to provide an approximate measurement for whether that interdisciplinary sensibility is being applied in the clinic.

By employing the philosophical insights that the pragmatists offer about truth, this article has invited consideration for how the things people hold to be true can be alternatively appreciated as knowledge made rather than found. The pragmatists redefine what it means to say something is true—not based on the generalization that conveys a sense of acultural objectivity, but instead as an expression of usefulness within a specific cultural setting. Pragmatism holds that truth is a perspective about what works. As such, the cultural pragmatism defended in this article maintains that patient truths are expressive of cultural functioning. Similarly, it holds that clinical truths are expressive of clinical usefulness. This perspective encourages appreciation for why divergent views about illness are important, and how attention to differences in knowledge can uphold the underlying ideals of cultural competence. Cultural pragmatism is not meant to replace previous competence models but instead to serve as

an epistemological foundation to appreciate the different perspectives individuals might introduce. In this way, cultural pragmatism aligns well with other efforts to prioritize pragmatism in efforts to speed up research translation (e.g., Glasgow, 2013), including implementation research focused on cultural adaptations of evidence-based interventions (Baumann et al., 2014; Cooper et al., 2020).

Clinicians might implicitly assume that scientific truths, including findings gained about culture, are factual, objective, and transcendent of cultural experience. But in so doing, they risk overlooking how clinical knowledge is similarly cultural and further risk prioritizing clinical knowledge over the cultural experience. At its core, then, the cultural competence proposed in this article asks clinicians to question the authority of clinical knowledge, cautioning against viewing it as factual and acultural and instead considering it as expressive of what works (or at least what *has* worked) in the clinical sphere. This is by no means an invitation for relativism but rather an approach that views truth as inescapably fluid, evolving, and constituted within the culture of providing care.[8]

However jarring the pragmatic notion of truth might be—that it defies conventional notions and scientific authority—it is instructive to note that seeing truth as a matter of contingency is congruent with other trends in the field. For example, the American Psychological Association, Presidential Task Force on Evidence-Based Practice (2006) defined "evidence-based practice" as consisting of three parts: (a) scientific evidence (both quantitative and qualitative), (b) clinical judgment, and (c) patient values. In the spirit of the arguments made in this article, note that the second and third components are distinct from a strict empirical gathering of facts. Moreover, the policy explicitly cautions against prioritizing scientific evidence by overlooking clinical judgment and patient preference. Evidence-based practice recognizes that "evidence" about what works in mental health exceeds scientific inquiry and, further, that it involves intersubjective, cultural process (see also Jackson, 2015; Tolin et al., 2015).

By reconceptualizing and clarifying what truth means in cultural competence, cultural pragmatism offers a conceptual framework to improve cross-cultural collaboration. Appreciating how the things we hold to be true are expressive of us—our ways of coping with the world, our fears, and our aspirations—safeguards clinicians from the risk of proving or asserting one set of truths over another. To the point of how adopting pragmatism in the clinic fosters cross-cultural exchange, Rorty (1982) wrote:

> Our identification with our community—our society, our political tradition, our intellectual heritage—is heightened when we see this community as *ours* rather than *nature's*, *shaped,* rather than *found*, one among many which men [*sic*] have made. In the end, the pragmatists tell us, what matters is our loyalty to other human beings clinging together against the dark, not our hope of getting things right. (p. 166, emphasis in original)

Such a sensibility would help foster recognition of cultural dignity, communication that addresses and responds to difference, and collaboration between patient and provider. This article has argued that a pragmatic reconceptualization of truth could help come closer to these goals of culturally competent care.

---

[8] To this point, clinicians might adopt what Rorty (1989) referred to as an attitude of irony, an awareness that "the terms in which [one] describe[s oneself, or justifies their truths] are subject to change, [and are based on a sense of] contingency and fragility of what [one] hold[s] to be true" (p. 74). That is because, according to the pragmatists, there is no final bedrock of truth clinicians could appeal to, no epistemological conclusion to the quest for knowledge about culture and how to treat different cultures. By Rorty's account, an ironist would still maintain what they hold to be true insofar as it works for them to do so—but they would recognize that it is liable to change—and consider that it works for others to maintain their truths as well. As Rorty recognizes, this does not mean that clinicians should stop attempting to gain more information about illness or culture—far from it. "Ironists have to have something to have doubts about," he writes, meaning that they have to maintain their truths and act upon those truths, while at the same time appreciating truth with a certain degree of tentativeness, that is to say, irony (p. 88).

References

Abramowitz, S. A. (2010). Trauma and humanitarian translation in Liberia: The tale of open mole. *Culture, Medicine and Psychiatry*, *34*(2), 353–379. https://doi.org/10.1007/s11013-010-9172-0

Abu-Lughod, L. (1996). Writing against culture. In R. Fox (Ed.), *Recapturing anthropology: Working in the present* (pp. 466–479). School of American Research Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to*

context, identity, and intersectionality. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Anderson, K. N., Bautista, C. L., & Hope, D. A. (2019). Therapeutic alliance, cultural competence and minority status in premature termination of psychotherapy. *American Journal of Orthopsychiatry*, *89*(1), 104–114. https://doi.org/10.1037/ort0000342

Baumann, A. A., Domenech Rodríguez, M. M., Amador, N. G., Forgatch, M. S., & Parra-Cardona, J. R. (2014). Parent Management Training-Oregon model (PMTO™) in Mexico City: Integrating cultural adaptation activities in an implementation model. *Clinical Psychology: Science and Practice*, *21*(1), 32–47. https://doi.org/10.1111/cpsp.12059

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, *23*(1), 67–82. https://doi.org/10.1007/BF01447045

Borrelli, B., McQuaid, E. L., Novak, S. P., Hammond, S. K., & Becker, B. (2010). Motivating Latino caregivers of children with asthma to quit smoking: A randomized trial. *Journal of Consulting and Clinical Psychology*, *78*(1), 34–43. https://doi.org/10.1037/a0016932

Brandom, R. (2011). *Perspectives on pragmatism: Classical, recent, and contemporary*. Harvard University Press.

Carpenter-Song, E. A., Nordquest Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, *58*(10), 1362–1365. https://doi.org/10.1176/ps.2007.58.10.1362

Chen, J., & Rizzo, J. (2010). Racial and ethnic disparities in use of psychotherapy: Evidence from U.S. national survey data. *Psychiatric Services*, *61*(4), 364–372. https://doi.org/10.1176/ps.2010.61.4.364

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Clifford, J., & Marcus, G. (2010). *Writing culture: The poetics and politics of ethnography*. University of California Press. (Original work published 1986)

Cooper, D. K., Wieling, E., Domenech Rodríguez, M. M., Garcia-Huidobro, D., Baumann, A., Mejia, A., Le, H. N., Cardemil, E. V., & Acevedo-Polakovich, I. D. (2020). Latinx mental health scholars' experiences with cultural adaptation and implementation of systemic family interventions. *Family Process*, *59*(2), 492–508. https://doi.org/10.1111/famp.12433

Corrigan, P. W., Angell, B., Davidson, L., Marcus, S. C., Salzer, M. S., Kottsieper, P., Larson, J. E., Mahoney, C. A., O'Connell, M. J., & Stanhope, V. (2012). From adherence to self-determination: Evolution of a treatment paradigm for people with serious mental illnesses. *Psychiatric Services*, *63*(2), 169–173. https://doi.org/10.1176/appi.ps.201100065

Davidson, L. (2016). The recovery movement: Implications for mental health care and enabling people to participate fully in life. *Health Affairs*, *35*(6), 1091–1097. https://doi.org/10.1377/hlthaff.2016.0153

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy: Theory, Research, & Practice*, *55*(1), 89–100. https://doi.org/10.1037/pst0000160

Dewey, J. (1998). *The essential Dewey, volume 1: pragmatism, education, democracy* (Vol. 1). Indiana University Press.

Drinane, J. M., Owen, J., & Kopta, S. (2016). Racial/ethnic disparities in psychotherapy: Does the outcome matter? *Testing, Psychometrics, Methodology in Applied Psychology*, *23*(4), 531–544. https://doi.org/10.4473/TPM23.4.7

Duncan, W. L. (2018). *Transforming therapy: Mental health practice and cultural change in Mexico*. Vanderbilt University Press. https://doi.org/10.2307/j.ctv167560w

Flynn, P. M., Betancourt, H., Emerson, N. D., Nunez, E. I., & Nance, C. M. (2020). Health professional cultural competence reduces the psychological and behavioral impact of negative healthcare encounters. *Cultural Diversity & Ethnic Minority Psychology*, *26*(3), 271–279. https://doi.org/10.1037/cdp0000295

Foronda, C. (2020). A theory of cultural humility. *Journal of Transcultural Nursing*, *31*(1), 7–12. https://doi.org/10.1177/1043659619875184

Geertz, C. (1973). *The interpretation of cultures: Selected essays*. Basic Books.

Glasgow, R. E. (2013). What does it mean to be pragmatic? Pragmatic methods, measures, and models to facilitate research translation. *Health Education & Behavior*, *40*(3), 257–265. https://doi.org/10.1177/1090198113486805

Gómez-Carrillo, A., & Kirmayer, L. J. (2023). A cultural-ecosocial systems view for psychiatry. *Frontiers in Psychiatry*, *14*, Article e1031390. https://doi.org/10.3389/fpsyt.2023.1031390

Gone, J. P. (2011). Is psychological science a-cultural? *Cultural Diversity & Ethnic Minority Psychology*, *17*(3), 234–242. https://doi.org/10.1037/a0023805

Gone, J. P. (2015). Reconciling evidence-based practice and cultural competence in mental health services:

Introduction to a special issue. *Transcultural Psychiatry*, *52*(2), 139–149. https://doi.org/10.1177/1363461514568239

Good, B. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge University Press.

Good, M. J. D., & Hannah, S. D. (2015). "Shattering culture": Perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry*, *52*(2), 198–221. https://doi.org/10.1177/1363461514557348

Guarnaccia, P. J., & Rodriguez, O. (1996). Concepts of culture and their role in the development of culturally competent mental health services. *Hispanic Journal of Behavioral Sciences*, *18*(4), 419–443. https://doi.org/10.1177/07399863960184001

Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, *69*(3), 502–510. https://doi.org/10.1037/0022-006X.69.3.502

Hannah, S. (2011). Clinical care in environments of hyperdiversity. In M. J. D. Good, S. D. Hannah, S. S. Willen, & K. Vickery (Eds.), *Shattering culture: American medicine responds to cultural diversity* (pp. 35–69). Sage Publications.

Hollan, D. (2022). James and radical empiricism in rural Indonesia. In N. Bubandt & T. S. Wentzer (Eds.), *Philosophy on fieldwork* (pp. 337–352). Routledge.

Huey, S. J., Jr., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, *10*(1), 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology*, *58*(3), 290–298. https://doi.org/10.1037/a0023284

Jackson, V. H. (2015). Practitioner characteristics and organizational contexts as essential elements in the evidence-based practice versus cultural competence debate. *Transcultural Psychiatry*, *52*(2), 150–173. https://doi.org/10.1177/1363461515571625

James, W. (1976). *Essays in Radical Empiricism*. Harvard University Press. (Original work published 1912)

James, W. (2000). *Pragmatism and other writings*. Penguin. (Original work published 1907)

Kam, B., Mendoza, H., & Masuda, A. (2019). Mental health help-seeking experience and attitudes in Latina/o American, Asian American, Black American, and White American college students. *International Journal for the Advancement of Counseling*, *41*(4), 492–508. https://doi.org/10.1007/s10447-018-9365-8

Kirmayer, L. J. (2005). Culture, context and experience in psychiatric diagnosis. *Psychopathology*, *38*(4), 192–196. https://doi.org/10.1159/000086090

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J. (2013). Embracing uncertainty as a path to competence: Cultural safety, empathy, and alterity in clinical training. *Culture, Medicine and Psychiatry*, *37*(2), 365–372. https://doi.org/10.1007/s11013-013-9314-2

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in mental healthcare. *HealthcarePapers*, *18*(2), 11–23. https://doi.org/10.12927/hcpap.2019.25925

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books.

Kleinman, A. (1997). *Writing at the margin: Discourse between anthropology and medicine*. University of California Press. https://doi.org/10.1525/california/9780520209657.001.0001

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS Medicine*, *3*(10), Article e294. https://doi.org/10.1371/journal.pmed.0030294

Kuhn, T. (1962). *The structure of scientific revolutions* (3rd ed.). University of Chicago Press. https://doi.org/10.7208/chicago/9780226458106.001.0001

La Roche, M., & Christopher, M. S. (2008). Culture and empirically supported treatments: On the road to a collision? *Culture and Psychology*, *14*(3), 333–356. https://doi.org/10.1177/1354067X08092637

Lakes, K., Lopez, S. R., & Garro, L. C. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, & Practice*, *43*(4), 380–396. https://doi.org/10.1037/0033-3204.43.4.380

Levinas, E. (1992). *Totality and infinity: An essay on exteriority* (A. Lingis, Trans.). Duquesne University Press. (Original work published 1969)

Lewis-Fernández, R., Aggarwal, N. K., Hinton, L., Hinton, D. E., & Kirmayer, L. J. (Eds.). (2016). *DSM-5 handbook on the cultural formulation interview*. American Psychiatric Publishing.

Lilienfeld, S., Lynn, S., & Lohr, J. (2014). *Science and pseudoscience in clinical psychology*. Guilford Press.

Llerena-Quinn, R. (2013). A safe space to speak above the silences. *Culture, Medicine and Psychiatry*, *37*(2), 340–346. https://doi.org/10.1007/s11013-013-9321-3

Londono Tobon, A., Flores, J. M., Taylor, J. H., Johnson, I., Landeros-Weisenberger, A., Aboiralor, O., Avila-Quintero, V. J., & Bloch, M. H. (2021).

Racial implicit associations in psychiatric diagnosis, treatment, and compliance expectations. *Academic Psychiatry*, *45*(1), 23–33. https://doi.org/10.1007/s40596-020-01370-2

Lopez, S. R. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 570–588). Wiley.

Lopez, S. R., Ribas, A. C., Sheinbaum, T., Santos, M. M., Benalcázar, A., Garro, L., & Kopelowicz, A. (2020). Defining and assessing key behavioral indicators of the Shifting Cultural Lenses model of cultural competence. *Transcultural Psychiatry*, *57*(4), 594–609. https://doi.org/10.1177/1363461520909599

Merino, Y., Adams, L., & Hall, W. J. (2018). Implicit bias and mental health professionals: Priorities and directions for research. *Psychiatric Services*, *69*(6), 723–725. https://doi.org/10.1176/appi.ps.201700294

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Nelson, A. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, *94*(8), 666–668.

Nichter, M. (1981). Idioms of distress: Alternatives in the expression of psychosocial distress: A case study from South India. *Culture, Medicine and Psychiatry*, *5*(4), 379–408. https://doi.org/10.1007/BF00054782

Nichter, M. (2022). From idioms of distress, concern, and care to moral distress leading to moral injury in the time of Covid. *Transcultural Psychiatry*, *59*(4), 551–567. https://doi.org/10.1177/13634615221115540

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). 'No-show': Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology*, *59*(2), 314–320. https://doi.org/10.1037/a0027091

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology, Research and Practice*, *45*(4), 283–290. https://doi.org/10.1037/a0037420

Patterson, C. H. (2004). Do we need multicultural counseling competencies? *Journal of Mental Health Counseling*, *26*(1), 67–73. https://doi.org/10.17744/mehc.26.1.j7x0nguc7hjh545u

Peirce, C. (1877). The fixation of belief. *Popular Science Monthly*, *12*, 1–15.

Popper, K. (1959). *The logic of scientific discovery*. Basic Books.

Putnam, H. (1995). *Pragmatism*. Blackwell.

Richardson, R. (2007). *William James: In the maelstrom of American modernism*. First Mariner Books.

Rorty, R. (1982). *Consequences of pragmatism: Essays, 1972–1980*. University of Minnesota Press.

Rorty, R. (1989). *Contingency, irony, and solidarity*. Cambridge University Press. https://doi.org/10.1017/CBO9780511804397

Santos, M. M., Nagy, G. A., Kanter, J. W., & Lopez, S. R. (2021). Applying a process-oriented model of cultural competence to behavioral activation for depression. *Cognitive and Behavioral Practice*, *28*(2), 127–146. https://doi.org/10.1016/j.cbpra.2020.11.007

Shevell, M. I. (2009). What do we call 'them'?: The 'patient' versus 'client' dichotomy. *Developmental Medicine and Child Neurology*, *51*(10), 770–772. https://doi.org/10.1111/j.1469-8749.2009.03304.x

Sue, D. W. (1990). Culture specific techniques in counseling: A conceptual framework. *Professional Psychology, Research and Practice*, *21*(6), 424–433. https://doi.org/10.1037/0735-7028.21.6.424

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*(6), 790–821. https://doi.org/10.1177/0011000001296002

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*(4), 440–448. https://doi.org/10.1037/0003-066X.53.4.440

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*(1), 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Taylor, J. S. (2003). Confronting "culture" in medicine's "culture of no culture." *Academic Medicine*, *78*(6), 555–559. https://doi.org/10.1097/00001888-200306000-00003

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

Thomas, K. R., & Weinrach, S. G. (2004). Mental health counseling and the AMCD multicultural counseling competencies: A civil debate. *Journal of Mental Health Counseling*, *26*(1), 41–43. https://doi.org/10.17744/mehc.26.1.r4h47gnw89eq2q4y

Tolin, D. F., McKay, D., Forman, E. M., Klonsky, E. D., & Thombs, B. D. (2015). Empirically supported treatment: Recommendations for a new model. *Clinical Psychology: Science and Practice*, *22*(4), 317–338. https://doi.org/10.1037/h0101729

Trimble, J. E., & Dickson, R. (2005). Ethnic gloss. In C. B. Fisher & R. M. Lerner (Eds.), *Encyclopedia of applied developmental science* (pp. 412–415). Sage Publications.

U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General*. U.S. Department of Health and Human Services.

White, M. (2009). *A philosophy of culture: The scope of holistic pragmatism*. Princeton University Press.

Wittgenstein, L. (2009). *Philosophical investigations*. Blackwell. (Original work published 1953)

Yahalom, J. (2019a). Pragmatic truths about illness experience: Idioms of distress around Alzheimer's disease in Oaxaca, Mexico. *Transcultural Psychiatry*, *56*(4), 599–619. https://doi.org/10.1177/1363461519847304

Yahalom, J. (2019b). *Caring for the people of the clouds: Aging and dementia in Oaxaca*. University of Oklahoma Press.

Yates-Doerr, E. (2018). Translational competency. *Medicine Anthropology Theory*, *5*(4). https://doi.org/10.17157/mat.5.4.579

Received September 20, 2022
Revision received March 6, 2023
Accepted March 11, 2023 ■