

# Reconsidering Rigor in Psychological Science: Lessons From a Brief Clinical Ethnography

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American psychologists have long defined their discipline by its methods, and ideas of rigor have been central to organizing its methodological boundaries. In pursuit of rigor, psychologists have emphasized carefully controlled experimental designs, highly scrutinized measurements, and sophisticated statistical analyses to produce generalized understandings of human behavior. The present study challenges the discipline to associate rigor with ethnographically informed inquiry contributing richly situated knowledge. The authors developed a 19-week clinical ethnography in partnership with a behavioral health clinic in a midwestern urban American Indian community health organization to understand how culture and culture concepts influenced clinical practice. Participants included 5 clinicians and 20 additional health organization administrators, staff, and volunteers involved with behavioral health services. Data collection entailed participant observation in all settings within the clinic (except client encounters), interviews with key personnel, and collection of clinic materials (e.g., clinical handouts). Data analysis was ongoing during data collection to identify patterns of interest. Following data collection, we conducted a thematic analysis of a semistructured interview with clinicians on culture and the clinic and then contextualized this interview analysis with reference to relevant patterns identified in the ethnographic data corpus. The findings highlighted a disjunction between how therapists thought about culture in the abstract during formal interviews (cultural reconnection) and how they described and demonstrated culture in day-to-day clinical practice (cultural reimagination). This contrast illustrates why a rigorous psychological science must embrace ethnographically informed modes of inquiry to represent, with specificity, contextualization, and vividness, the shared and divergent understandings and circumstances facilitating and constraining behavior in natural settings.

*Keywords:* psychological science, rigor, ethnographic inquiry, American Indians

American psychologists have long defined their discipline by its methods, which are regularly referenced as distinguishing it from other

ways of knowing about the human condition by virtue of leveraging scientific inquiry to convincingly parse fact from fiction (Smith, 1997). However, as ideas of science have come under the influence of Enlightenment understandings of progress as pursued through the systematic application of reason to discover and control nature (per laws of nature; Fishman, 1999), the scientific standing of psychology has been repeatedly called into question for its dissimilitude from popular natural science research methodologies (e.g., Benjamin, 1986; Coon, 1992; Lilienfeld, 2012). In response to recurrent social and professional skepticism, many influential psychologists have embraced a hard–soft

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science divide, distinguishing more rigorous “hard” sciences from less rigorous “soft” sciences in attempts to reposition psychology among natural sciences at the hard end of this spectrum and bolster its scientific standing. Lilienfeld (2012), as a recent example, rebutted assertions that “psychology does not use scientific methods” with methodological observations supporting an argument that “many areas of psychology are every bit as scientific as traditional ‘hard’ sciences, including physics and chemistry” (p. 115). Echoing calls by 19th- and 20th-century behaviorists for adopting natural science methodologies in psychology to ensure its future as a socially valued science (e.g., Watson, 1913), contemporary psychologists have come to prize natural science methodologies and embrace their associated standards of rigor in hopes of being valued (and funded) like a “real” science (science, technology, engineering, and mathematics [STEM] research is funded 20:1 over social sciences; e.g., National Science Foundation, 2018).

Central to these debates over the appropriate forms and standards of scientific inquiry in psychology have been concerns about perceived *rigor*. Price (2011), reporting on an ongoing strategic initiative to get psychology recognized as a STEM discipline (see American Psychological Association [APA], Presidential Task Force on the Future of Psychology as a STEM Discipline, 2010), explained:

People use a sliding scale of rigor when it comes to rating the various fields of science, placing them on a continuum from soft to hard science. Social science and anthropology rank as soft sciences. Physics and astronomy are hard. And psychology? “They think of psychology as being somewhere in the middle,” [an APA executive] said. In addition, only about 30% of people believe psychologists primarily use the scientific method. (p. 32)

Framed as a public perception problem requiring methodological reform in psychology to more closely approximate the imagined rigor of STEM and a popular myth of “the scientific method” (see Proctor & Capaldi, 2001), disciplinary leadership has taken to associating ideas of rigor with procedural assurances of replicability in the production of timeless, context-free, nomothetic knowledge via the hypothetico-deductive method (Proctor & Capaldi, 2001; Wertz, 2011). Reflecting this procedural ideal, which attempts to approximate the scien-

tific method myth, psychologists have come to associate scientific rigor with research involving carefully controlled experimental designs, highly scrutinized measurements, and sophisticated statistical analyses (Camic, Rhodes, & Yardley, 2003; Cronbach, 1957; Willig, 2001).

Although aspirations toward procedural rigor have facilitated important contributions to psychological knowledge and practice in several domains (e.g., evidence-based practice considerations in clinical, school, and other settings; see APA, 2003), the adoption of such a narrow understanding of rigor, like procedural assurances of replicability, for all research irrespective of the phenomenon of interest and circumstances of study, makes for bad science. Ironically, it also moves psychology away from the actual methodological diversity behind progress in the natural sciences (see Proctor & Capaldi, 2001). Favoritism toward methods and methodologies that best approximate the scientific method myth unnecessarily marginalizes valuable areas of inquiry, limits psychologists’ ability to respond creatively and pragmatically to challenges in research, and undermines the discipline by circulating inaccurate understandings of human experience, development, and behavior. To support this argument for pluralism over parochialism, we outline one domain illustrative of these conceptual problems in psychology—culture research in clinical contexts—and we highlight the seriousness of real-world consequences for marginalized and misrepresented peoples by focusing on American Indian misrepresentation in psychological research on culture and behavioral health. We then present findings from an urban American Indian behavioral health clinical ethnography as a case illustration to further clarify the problem of rigor for psychology and society, and we glean insights into research standards better suited to understanding human behavior and supporting the health and wellness of diverse peoples.

### Culture Research

One domain of inquiry severely constrained by psychology’s narrow, procedural idea of rigor has been research on culture, where the incentive to emulate the natural sciences has inundated the discipline with reductionist research imagining culture as something found in

the minds, beliefs, and behaviors of minoritized ethno-racial group members in the United States and “non-Western” populations internationally. In the United States, this work has taken identity as its organizing framework for conceptualizing diversity as generalized dispositional differences of minoritized groups, typically ethno-racial minorities recognized in the U.S. census, distinguishing them from each other and their majority peers (Hollinger, 1995; Weinrach & Thomas, 2004). This intrapersonal focus on a limited set of fixed characteristics of minority group members allows for standardized measurement and classification of minoritized identities by numerically describing their properties and analyzing their associations with other variables of interest (e.g., educational achievement, health outcomes). However, absent attention to social and historical processes giving form to contemporary identity categories and institutions involved in their societal reproduction, this predominant pattern of identity research risks naturalizing these categories as fixed and immutable forms of difference, misrepresenting human experience, and reinforcing existing hierarchies of power and privilege (Brubaker, Loveman, & Stamatov, 2004; Omi & Winant, 1994). Teo (2010) characterized this empirical reification of constructed categories as natural, timeless states of human existence as a form of *epistemological violence* psychologists are prone to perpetrate, in part, due to their misguided understandings of rigor in research.

Looking outside the United States, identity research remains an influential framework for studying human diversity in terms of stable, intrapersonal factors shared by minoritized group members; however, cross-cultural research on self-construal (per Markus & Kitayama, 1991) contributes an additional, parallel framework for conceptualizing culture in ways that are similarly amenable to procedurally rigorous research. Theorizing self-construal as tied to nation-states or geographic regions (e.g., “the West”), rather than minoritized group membership, this work has ushered in a host of empirical research studies comparing basic psychological processes (e.g., cognition, emotion, motivation) between “Eastern” and “Western” self-construals. In these studies, tendencies in self-construal are typically associated with citizenship, with East Asian nationalities more likely to demonstrate an interdependent (“East-

ern”) self and North American or Western European nationalities more likely to demonstrate an independent (“Western”) self (see Markus & Kitayama, 1991; Triandis, 1995). Findings have asserted culture to be foundational to psychological knowledge, shaping the most basic of psychological processes, but primarily in its limited manifestation as either an interdependent or independent self-construal (Hermans & Kempen, 1998). Although more recent research on culture and self-construal attempts to counter this reductionist trend by highlighting extrapersonal, dynamic dimensions of culture (e.g., Markus & Kitayama, 2010), psychologists interested in conceptualizing culture to fit experimental designs, standardized measurements, and quantification for statistical analyses have struggled to escape the allure of cultural essentialism (e.g., describing human diversity in terms of individualist and collectivist cultures). As a result, many cross-cultural psychologists continue to describe human behavior as predictably informed by as few as two self-construals operating uniformly across the globe. Even researchers critical of this East–West binary have been more inclined to refine existing measures of self-construal than interrogate their underlying assumptions about culture as a stable group orientation with near law-like properties (akin to personality trait research at the group level, per Shweder, 2007) understood best using natural science research methodologies (e.g., Vignoles et al., 2016).

Circulation of essentialist culture concepts for understanding human diversity does not occur in a sociopolitical vacuum; rather, its refractions through broader social discourse can give voice to deep-seated desires for colonial domination that leverage essentialisms to reinforce racial power hierarchies (Holtz & Wagner, 2009; Malik, 1996). Historically, psychologists have played an outsized role in reproducing and scientifically validating essentialist representations of culture (Williams, 1976), which for American Indians has long been a point of tension between settler-colonial efforts at Indigenous erasure and Indigenous efforts to endure as sovereign, self-determining peoples (Barnd, 2017; Wolfe, 2006). Settler-colonial efforts at Indigenous erasure regularly represent American Indians in essentialist terms, often by tying Indigeneity to a limited set of beliefs and behaviors—or biological properties (e.g., DNA;

see TallBear, 2013)—that, when (inevitably) altered in the future, will terminate geopolitical claims to sovereignty via incorporation into the settler state (see Dennison, 2014; Jaimes, 1992). Although more recent culture research has applied the lens of self-construal to representing American Indians, these works have often been (co)authored by Indigenous researchers who highlight the limitations of this framework for understanding Indigenous peoples and call for additional attention to social and political context (e.g., Fryberg & Markus, 2003). More prominent and problematic has been identity research, which has infused psychological knowledge with essentialist representations of culture as fixed constellations of attributes that, whether mapped onto unidimensional or multidimensional models, represent American Indian culture(s) as static, uniform, and—more often than not—trapped in the past or tied to pathology in the present (Gone, 2007; Waldram, 2004). Absent meaningful alternatives, these essentialist representations—scientifically validated through procedurally rigorous empirical research studies—are then taken up in applied contexts, like behavioral health, where they can misguide, and even undermine, intervention efforts.

### Clinical Contexts

Although culture and human diversity are frequently listed among the principal concerns of clinical knowledge, institutions, and practices, psychologists' predilection for essentialist culture concepts amenable to procedurally rigorous research has spilled into clinical contexts to create new challenges in responding meaningfully to human diversity. Although more conceptually sound and practice-relevant approaches to culture in clinical contexts have been proposed in the behavioral health literature (e.g., Groleau, Young, & Kirmayer, 2006; Kleinman & Benson, 2006; Saint Arnault & Shimabukro, 2012), such alternatives have been largely eclipsed by attention to intrapersonal attributes—the beliefs, values, and behaviors—of ethno-racial minority group members (Hollinger, 1995), which can be captured using highly scrutinized measurements, interpreted via statistical analyses, and tested in experimental designs (e.g., controlled trials; Castro, Barrera, & Martinez, 2004). Researchers have

imagined these distinct *group orientations* to be so simple, uniform, and predictable that clinical professionals can learn about them with relative ease and accommodate their differences in practice (i.e., cultural competence training, per Sue & Sue, 1990). This literature highlighted the distinct behavioral health interests of clients from minoritized groups, which was of great value at the time, but it did so by invoking essentialist representations of minoritized group members as lacking agency, with their beliefs and values predictably determined via a top-down imposition of thin, stereotyped cultural scripts (Adams, Kurtiş, Salter, & Anderson, 2012; Guarnaccia & Rodriguez, 1996; Kirmayer, 2012; Shaw, 2005; Taylor, 2003). Not surprisingly, this concept of culture as group orientation has proven ill-suited to understanding human diversity in clinical contexts (Harlem, 2002), and as a result, therapists have come to widely view culture as a barrier to treatment (Quintero, Lilliot, & Willging, 2007).

Despite intense critique, the group-orientation culture concept continues to inform the bulk of disciplinary responses to human diversity in clinical research and practice (e.g., APA, 2003; U.S. Department of Health and Human Services, 2001). Although cultural competence training remains popular, additional momentum has built behind projects of cultural adaptation, which repurpose the same group-orientation idea to guide a tailoring of behavioral health interventions' surface-level features to reflect the beliefs, values, and behaviors of minoritized groups (see Castro et al., 2004; Lau, 2006). Despite its clear limitations in theory and practice, psychologists continue to think about culture in terms of group orientations because, as designed, these formulations enable procedurally rigorous research. As Castro and colleagues (2004) extolled, the cultural adaptation framework promises an account of diversity amenable to "rigorous science-based evaluation and testing" with "controlled trials" (p. 45). Thus, motivated more by commitments to narrow views of rigor than the accuracy or utility of knowledge produced, psychologists continue to unwittingly cling to group orientation as the predominant framework for conceptualizing culture in clinical research and practice.

Both cultural competence and cultural adaptation research programs have been influential in American Indian behavioral health, leading

researchers to attempt to distill key intrapersonal elements of an Indigenous group orientation that can inform clinical knowledge, institutions, and practices. Weaver (2004), for example, asked open-ended survey questions of Indigenous service providers to ascertain what knowledge, skills, and attitudes “helping professional[s] should] bring to working with Native American clients or groups in a culturally competent manner” (p. 22), presenting common themes as insights into a group orientation informative of more effective clinical work with American Indian and Alaska Native clients. Similarly, cultural adaptation research references elements of Indigenous culture to inform adaptations of evidence-based interventions for American Indians (e.g., trauma-focused cognitive behavioral therapy [BigFoot & Schmidt, 2010]; life skills curricula [LaFromboise & Howard-Pitney, 1995]). Although both research programs enabled American Indians to represent themselves and their experiences of distress in the behavioral health literature, to a degree, these representations are then flattened, fixed in intervention protocol, and presumed uniform and stable within and across Indigenous communities to characterize diverse peoples with a single group orientation that can be measured in a standardized fashion, analyzed statistically, and evaluated in controlled trial research designs.

### Culture Theory

While psychologists perseverate on misguided culture concepts, their contemporaries in the social sciences and humanities have productively reformulated understandings of culture to reflect an *emergent negotiation* between individual actors and a dynamic, shared set of views and practices in constant flux under the influence of societal change (Burke, 2009; Good, 1994). This concept of emergent negotiation, though, foregrounds human agency, impermanence, and situatedness, none of which lends itself well to procedurally rigorous research, which instead requires stability, uniformity, and consistency. Moreover, this negotiation occurs at multiple levels—within communities and health organizations (e.g., “the culture of the clinic” [Gone, 2007]), in interactions with institutions (e.g., health-care systems), and through exchanges with global networks of discourse

(Modood, 2013; see Fassin & Rechtman, 2009, for an illustrative clinical example). Capturing culture as conceptualized here requires intensely contextual, exploratory inquiry embedded in the local moral and social fabric in which negotiations occur (i.e., ethnographically informed inquiry). However, rather than adopt research methodologies well suited to capturing this dynamic process of emergent negotiation, psychologists committed to procedural rigor continue to overlook critique, imagining themselves as capturing communal traits that generalize to most group members in research on minoritized group orientations.

Qualitative psychology, often understood and represented in opposition to quantitative research norms (e.g., Camic et al., 2003; Willig, 2001), has been unencumbered by such narrow ideas of rigor and has roundly rejected many natural science research methodologies to offer more constructivist and particularistic analyses of human experience, development, and behavior (Morrow, 2005; Wertz, 2011). Culture research in qualitative psychology has thus avoided many of the essentialist pitfalls that undermine the work of quantitative colleagues. However, to the extent that qualitative research explores culture via a sole focus on individual meaning-making, or “lived experience and participant-defined meanings” (Willig, 2001, p. 11), it risks mistaking research participants’ talk about culture for culture itself. This represents a distinct challenge. Although participant meanings have been an invaluable source of idiographic understanding, instrumental in challenging the hegemony of “hard” science methodologies and nomothetic knowledge, their emphasis in culture research often reflects unrecognized Enlightenment assumptions about reason as the central organizer of human behavior (Shweder, 1984). Centering nonrational motivators of human behavior highlights additional limitations of common qualitative research methods and methodologies, which often presume participants can “off the top of their heads . . . tell what they know, know what they are talking about, and keep their answers short” for a brief, one-off interview or focus group (Shweder, 1996, p. 21). The process of emergent negotiation is rarely apparent to the actors involved, and it is often shaped by distal circumstances. Therefore, meanings made about culture are more often reflective of post hoc

rationalizations than insights into culture itself. Thus, although qualitative psychology has avoided many essentialist traps common to quantitative culture research, to study culture as an emergent negotiation, data collection must extend beyond participant responses to investigator queries to offer a richly contextualized and detailed picture of particular negotiations of culture and the role of culture talk (i.e., talk involving culture concepts) in shaping those processes.

In many American Indian communities, both culture and culture talk have been integral to issues of health and wellness. American Indian peoples were first introduced to a culture concept in the context of European and Euro American theories of cultural evolution, which functioned as a conceptual tool justifying Indigenous extermination, land dispossession, and forced assimilation (Williams, 1976). In response, American Indians have repurposed culture talk with new concepts that shifted culture's meaning from something they lacked (as "savages") to the centerpiece of national movements for empowerment (à la "cultural revitalization"; see Nagel, 1996). In this way, culture concepts function as sociopolitical tools, and culture talk functions, often only with partial awareness, to discursively frame American Indian health in ways that reflect either settler-colonial or Indigenous interests. For example, the concept of culture as *tradition* has become incredibly popular in American Indian behavioral health, in part, for its utility in resisting top-down impositions of clinical concepts and practices by behavioral health professionals and allowing for self-determined understandings and practices related to health, healing, and wellness (e.g., Echo-Hawk, 2011; French, 2004). Clinical contexts have thus become prominent sites of tension between settler colonialism and Indigenous resistance, with power negotiated, in part, through competing patterns of culture talk that differently frame American Indians and their health interests. Culture research in American Indian behavioral health requires wading into this complex interplay of culture and culture concepts (e.g., group orientation, tradition) to illuminate dynamic negotiations of health and wellness in relation to specific cultural communities, clinical institutions, and global discourses of health.

### The Present Study: A Brief Clinical Ethnography

Although only an afterthought in most clinical settings, culture and its role in supporting health and wellness are of prime concern for clinics funded by the federal Indian Health Service (IHS) to offer services tailored to the health needs of American Indian communities. This makes IHS-funded clinics ideal settings to learn about how culture and culture concepts operate within health fields, generally, and American Indian behavioral health, specifically. Toward this end, the first author partnered with an IHS-funded behavioral health clinic in a midwestern city to undertake research capable of illuminating the culture of the clinic and, within it, the role of culture concepts in shaping the therapeutic services offered. Importantly, urban American Indian communities differ in substantive ways from rural and reservation-based communities (Lobo & Peters, 2001), and in addition to recognizing commonalities among many urban American Indian communities (e.g., the roles of federal relocation programs and booming auto industries on the growth of midwestern urban American Indian communities [Snipp, 1992]), it is important to recognize differences in how each has been shaped by particular sets of actors, local geographies, and histories of settler-colonial violence and Indigenous resistance (for instructive examples of this specificity, see Barnd, 2017; Child, 2012; Thrush, 2007). The present study represents an instructive snapshot in time of one urban American Indian community and the behavioral health clinic charged with supporting its health and wellness. Although the issues touched upon in this work will likely be familiar to many urban American Indian behavioral health settings, the particulars of each issue should not be expected to generalize far beyond this clinic and its particular history, geography, and influential actors (for more local context, see Hartmann, 2016).

Prior to the present project, the first and third authors had come to know many of the clinic's clinicians, staff, and administrators through previous research collaborations, which were well received and laid an important relational foundation of trust. Notably, the behavioral health clinic was one department in a larger community health center established by members of a local urban American Indian community to

meet a range of community health needs (e.g., health education, cooking classes, basic medical care). The clinic was also a clinical training site for a nearby master of social work (MSW) program, and as a result, it not only housed five MSW clinicians but also six MSW student trainees and one cultural aide available for clinical consult but primarily involved in other health center services (e.g., facilitating a women's talking circle, exercise classes). Ethnographic attention focused most intensely on the five clinicians (4 female, 1 male; mean age [ $M_{age}$ ] = 34.2 years; 3 identified as Native) as actors of greatest influence over day-to-day clinic operations; however, it extended to include all six MSW students, the cultural aide, four administrators, several staff members from the larger health center, and one community elder who was highly involved in the clinic and health center (e.g., served on advisory boards, appeared regularly for meetings). Data collection was open-ended and organized to triangulate participant observation, which spanned all subsettings within the clinic except client encounters, with interviews (semistructured and informal/impromptu) and clinic materials collection (e.g., service brochures, clinical handouts, website content, photographs documenting clinic space).

In project-planning meetings with clinicians, who shared an understanding of culture as operating in nonapparent ways that are often difficult to articulate, ethnography was agreed to be ideally suited to developing the desired picture—vivid and well contextualized—of culture in this clinic. Although ethnography has been repurposed by psychologists for various functions, here we applied ethnography to its primary task of rendering a cultural analysis of human behavior (Chambers, 2000; Shweder, 1996). Whereas a psychological analysis would explain clinician behavior in terms of familiar intrapsychic factors, often centering on reason or rationality, cultural analysis looks to the complex matrix of semiotic, expressive, and context-bound influences (i.e., culture) to explain human behavior in natural settings (D'Andrade & Strauss, 1992; Shweder, 1986). Definitions of culture abound; however, to organize data collection, we adopted Shweder's (1996) definition of culture as “a reality lit up by a morally enforceable conceptual scheme composed of values (desirable goals) and causal

beliefs (including ideas about means-ends connections) that is exemplified or instantiated in practice” (p. 20). Three domains for ethnographic attention are highlighted in this definition: (a) ideas about what the world is like, (b) evaluative norms shared by a moral community (i.e., the clinic), and (c) practices expressive of these shared understandings. Data collection focused on fleshing out these three domains of emergent negotiations of culture in this clinic. Finally, in response to motivating interests of clinic partners and time constraints imposed by the first author's graduate training program, attention to narrow clinical practice issues (e.g., how exposure therapy here differed from its manualized form) were of less interest than broader issues of how distress was interpreted and how therapeutic services were organized and delivered in response.

Clinicians were invested in this project because they understood culture to be important in American Indian health and regularly talked about culture in relation to the clinic's behavioral health services. To parse their use of culture concepts from the culture of the clinic, data analysis proceeded in three steps. First, as an exploratory, theory-building endeavor, data analysis was ongoing throughout data collection, with recurrent themes and themes immediately relevant to our research questions receiving greater ethnographic attention and scrutiny (e.g., collecting additional data to support or refute patterns). After 19 weeks, this ongoing analysis indicated theoretical saturation, and data collection ceased to allow for additional, in-depth analyses. Then, in Step 2, transcripts from a semistructured interview with clinicians on culture and the clinic were analyzed via inductive thematic analysis with semantic coding to capture how clinicians thought and talked about culture in relation to their clinical work (Braun & Clarke, 2006). Initial coding by the first author was audited by the second and third authors to produce a final codebook of 26 codes relating to 20 themes that was then reapplied to all five clinician interview transcripts by the first author. These 20 themes were conceptually organized into 4 themes with 16 subthemes, and only 3 themes and 4 subthemes were relevant to our motivating question about culture in the clinic and endorsed by all five clinicians (a natural cutoff distinguishing shared patterns of culture talk from idiosyn-

cratic uses of the culture term). Finally, in Step 3 of the analytic process, we turned to the larger corpus of ethnographic data to more fully understand the results of our psychological analysis of interview transcripts. This involved drawing upon patterns documented in field notes from participant observation, informal interviews, and clinic materials to contextualize the picture of clinical practice painted by clinicians in interviews. Here, to highlight the distinctive understandings that resulted from psychological versus cultural analysis of human behavior, we present findings from analytic Steps 2 and 3 in sequence as interview findings and ethnographic findings.

### Interview Findings

The results from our interview analysis revealed that all five clinicians invoked ideas about *cultural disconnect* and *cultural reconnect* as an organizing framework for understanding culture in this clinic. These two themes were causally connected within a metanarrative that explained urban American Indian suffering in terms of cultural disconnect and healing in terms of cultural reconnect, which Ellis (pseudonym) succinctly explained: “[culture] is [an] extremely important, fundamental, part of your being, that being removed from it, especially . . . violently, is extremely disruptive and there is potential for healing by reconnecting with that culture.” The third theme, *Native essence*, referenced clinicians’ belief in an inextricable connection between contemporary American Indians and their Indigenous ancestors, and it tied processes of cultural disconnection and reconnection to the precolonial culture and lifeways of clients’ Indigenous ancestors.

All five clinicians engaged this metanarrative of disconnect/reconnect when asked about culture and clinical practice in the abstract, and as a result, their interview responses framed behavioral health treatment as both an intrapersonal project of self-discovery aimed at reanimating clients’ Native essence and a sociopolitical project of reversing the effects of colonial violence by reintroducing the precolonial cultural forms from which urban American Indians had been disconnected. Operating within this framework, clinicians described hardship among urban American Indians as the consequence of acculturative processes instigated by *colonial*

*violence* and culminating in *identity distress*, fueling behavioral health problems today. Charlie explained:

When you think about the context of historical trauma, like that loneliness or that disconnect from those that came before you, or intergenerational trauma. . . . Based off some of the teachings, long before boarding schools and things like that, people lived life and they lived life well. And there was not as much turmoil. . . . Things were handled much differently. And so I think that everybody has their own level of acculturation. . . . And when thinking about distress, I look at that . . . and how . . . identity distress impacts their maladaptive and adaptive coping skills or normative functioning.

Whereas Charlie mentioned “historical trauma” and “intergenerational trauma,” clinicians used a variety of terms in referencing colonial violence (e.g., “genocide,” “colonization,” “boarding schools,”) as the catalyst for a pivotal shift away from a time when Native people “lived life well” to the “identity distress” of today that inhibits urban American Indians’ ability to cope with stress and function normally. For clinicians, this was a shift in developmental trajectory, from an idyllic precolonial past where connection to culture created positive health outcomes to a modernity in which disconnection from that culture inevitably creates “turmoil” and poor health.

In response, cultural reconnect proposed reintroducing clients to precolonial cultural forms in therapy to reorient developmental trajectories back toward the culture, lifeways, and health of Indigenous ancestors. As a result, clinicians described engaging clients with cultural teachings and activities in therapy to foster *spiritual wellness* and *new perspectives* on Native culture and self. Blair imagined the following clinical treatment scenario:

Maybe you’re meeting with your therapist, and as part of that you are processing and learning . . . about colonization and historical trauma and how these . . . symptoms that you are experiencing—you start to heal in one area. Like the depression and anxiety starts to decrease. And then, suddenly, because you are able to have this conversation, [you think] “I would like to learn more about this” or “I would like to do these things.” Then maybe some of that internalized racism starts to lessen . . . so I think there’s a lot of different ways that culture can kind of manifest in someone’s healing.

Like Blair, through contextualizing urban American Indian clients’ distress in relation to diverse forms of colonial violence, clinicians



imagined therapy could catalyze iterative cycles of cultural reconnection via increased interest in and engagement with traditional activities (i.e., “learn more about this” and “do these things”) and gradual recovery of one’s true self as a Native person (i.e., “internalized racism starts to lessen”). Clinicians imagined reconnection as filling a void, “like a hole has been filled in you because it’s who you are” (Ellis), and taking spirituality as a defining feature of Indigenous culture(s), expressly spiritual teachings and practices were deemed most effective in reorienting clients from dysfunctional modernity, back toward precolonial harmony, by reanimating their Native essence—or, as Charlie put it, their “original self as a Native person.”

Thus, by asking about culture in a semi-structured interview, clinicians offered a clear and consistent response that framed behavioral health services as departing from clinical practice norms in substantive ways to account for differences in the lives of the urban American Indians. However, concrete observations of clinical practice raised several questions about this picture of the clinic. For instance, more than half of clients seen at the clinic did not identify as Native, and although three of the five clinicians did, none claimed the requisite knowledge or community credentialing to represent the cultural forms described (e.g., traditional teachings). Moreover, nearly all client encounters were structured by 60-min individual therapy sessions, which suggested the bulk of clinicians’ time with clients was not spent engaged in the kinds of activities one might imagine as vital to reconnection with precolonial lifeways.

### Ethnographic Findings

Whereas asking clinicians about culture in the abstract resulted in culture talk framed by the disconnect/reconnect metanarrative, concrete descriptions and demonstrations of clinical practice over 19 weeks painted a different picture. In pre- and posttherapy descriptions of session activities, for example, clinicians noted that most of their time was spent delivering familiar forms of high-quality behavioral health care and case management. Specifically, they described an eclectic use of popular therapeutic techniques. For example, in clinical supervision, after being told “this might be a good case for developing a trauma narrative,” a clinician

proceeded to suggest this new treatment direction in their next therapy session with a client who had previously been working to “challenge negative cognitive distortions.” In this way, rather than operate within rigid clinical frameworks or offer manualized empirically supported treatments, clinicians flexibly deployed a range of pragmatic clinical techniques to achieve specific goals in therapy. Similarly, struggling to find “skills that worked” for a client with anxiety, a clinician was pleased to find that the client really seemed to enjoy and benefit from a “mindfulness exercise.” Rather than adopt a broad mindfulness-based therapeutic protocol, the clinician incorporated this mindfulness exercise into an established routine of supportive listening, problem-solving, behavioral activation, and case management, all of which reflect national standards for good clinical social work practice. In contrast to interview responses, which suggested a major departure from professional norms for clinical care, this clinic seemed more remarkable for its ability to deliver high-quality services despite the many challenges common to community behavioral health care (e.g., high caseloads, meager funds).

Engagement with Native cultural forms in therapy, clinicians clarified, was most notable in smudging with clients—a spiritual practice familiar to many Native peoples that varies in form but often involves the burning of dried plant “medicines,” sometimes in a hand-sized abalone shell, such that those involved allow the rising smoke to pass over them—and in treatment-planning activities when clinicians invited clients to engage with representations of Medicine Wheel and Seven Grandfather-Grandmother teachings. In role-plays of how these teachings were incorporated into therapy, it became clear that clinicians were not offering teachings, per se, but instead had created decontextualized representations of these teachings for use as clinical tools in support of standard, well-regarded psychotherapy processes. Dani demonstrated:

I’ll explain the Medicine Wheel. . . . When it comes to balance, we’re composed of all different—we’re not just our mind. Not just our body . . . and from this perspective there are . . . four areas . . . the spiritual, mental, physical, and emotional aspects of us. And so, if a goal is balance, we need to address the whole person, not just one aspect of ourselves.

Drawing attention to a single-page handout depicting a Medicine Wheel, Dani continued:

I start . . . “I remember last week when we met the reason for your wellness journey was your depression. . . .” And then from there I start in the East and work my way around [clockwise]. I ask them the questions, “When it comes to your emotional well-being, what would you like to work on?” Or your mental well-being, then your physical. . . . And so I literally write what they want. . . . Sometimes it’s easy, sometimes it’s difficult. Sometimes it’s very long . . . sometimes it’s bullet points. I kind of meet the client where they’re at.

Here, Dani demonstrated a broad and consistent pattern of how, absent substantive teaching or instruction, clinicians were engaging clients with recognizable symbols of Indigeneity (e.g., the Medicine Wheel) that had been stripped of traditional context and meaning to encourage clients’ ascription of their own, personal meanings. The Medicine Wheel activity thus served to support client introspection and reflection regarding “spiritual, mental, physical, and emotional aspects” of self and well-being to better understand their distress in a more holistic sense and imagine possibilities for its alleviation through therapy (i.e., clarify “reasons for your wellness journey” and “what would you like to work on”). Seven Grandfather-Grandmother teachings were used similarly with clients as decontextualized words—*truth, love, respect, bravery, honesty, humility, wisdom*—organized in another handout to structure discussion of “what your strengths are and things you want to work on” (Ellis) prior to treatment planning. Importantly, framing treatment in terms of client strengths, rather than deficits, and encouraging reflection and introspection during treatment planning reflect familiar, well-regarded psychotherapy processes. Rather than incorporating traditional teachings into therapy with clients as imagined in abstract talk of culture in the clinic, behavioral health here was principally defined by a pattern of repackaging high-quality clinical practices and processes with added, pliable symbols of Indigeneity. As Blair once noted, “We talk about the medicine wheel and . . . traditional things, and . . . it’s interesting, we’re collecting the same information [as other clinics] . . . but it is different. It could be a very different experience.” Rather than change clinical practice, representations of Native culture served to create a different, more

appealing experience of talk therapy and support services for clients.

Importantly, a different pattern characterized clinicians’ smudging practice, which was a conspicuous feature of behavioral health care in the clinic. The smell of burnt sage often filled the air, and four plant medicines (tobacco, sage, sweetgrass, cedar) were prominently displayed in the clinic’s common workspace and in each therapy room on a side table. As Alex noted, “Smudging is a big one. People do it all the time.” Charlie explained:

All of our staff . . . maybe with the exception of our newest member . . . are comfortable explaining what each medicine is and what it can be used for. That can also be because there’s a pamphlet that goes along with it.

Charlie was correct that nearly all clinicians and trainees were comfortable explaining the what, how, and why of smudging to clients, as they understood it, offering the kind of instruction or teaching absent in Medicine Wheel and Seven Grandfather-Grandmother activities. Instead of using the referenced pamphlet, though, clinicians and trainees described learning to smudge from the clinic’s cultural aide and each other. However, whereas the cultural aide ascribed particular purposes to each of the four plant medicines and taught adding all four to a smudge, clinicians described only ever using sage and communicated many different purposes for this practice with clients (e.g., “calming racing thoughts,” building “the therapeutic alliance,” “clear[ing] a room of tension,” “alleviat[ing] depressed mood,” cleansing a space of “bad energy”).

Although smudging occurred every day, multiple times a day, in and outside therapy sessions, two clinicians were able to draw upon experience in Native community drum and singing groups to offer additional healing practices in therapy with clients. Like smudging, drumming and singing constituted brief healing practices that fit easily within a 60-min therapy session, but only drumming occurred during the 19 weeks of data collection, and only with a single client. Singing was mentioned as having been used with two clients prior to the start of data collection. Thus, drumming and singing were not regular offerings at this clinic like smudging, but brief healing practices like these reflected a distinct pattern of clinical practice in

which clinicians retained interpretive authority over Native cultural forms to explain their meanings to clients. Rather than affect healing via professionally familiar intrapersonal processes of introspection and therapeutic talk, smudging, drumming, and singing allowed contemporary Native community healing traditions and health logics to be represented in the clinic in ways that approximated the ancestral cultural forms described in the disconnect/reconnect metanarrative. However, in practice, only two clinicians had the requisite training and community credentialing to engage with these practices in this manner (i.e., with conventional Native community meanings intact).

In observing clinicians and clinical practice in concrete terms via role-playing of clinical techniques and impromptu interviews before and after therapy sessions, researchers identified two consistent patterns. The first, more predominant pattern pertained to what clinicians described as cultural teachings, and it involved the use of recognizable symbols of Indigeneity disconnected from their traditional meanings to serve as clinical tools supporting familiar clinical processes: establishing a strengths-based approach to psychotherapy and facilitating more holistic client introspection. Whereas this engagement with Native culture in therapy located interpretive authority over cultural forms in each client and relied upon clinically familiar intrapersonal change processes to affect healing, clinicians' use of brief Native community healing practices, like smudging, functioned altogether differently. This second pattern of engaging Native culture in therapy located interpretive authority over cultural forms in clinicians who explained their meanings to clients and attributed their therapeutic effect to a mix of clinically familiar and unfamiliar change processes. Although familiar intrapersonal change mechanisms were more frequently described (e.g., relaxation), two clinicians familiar with these practices as engaged in Native community settings were able to inform their use with distinctly Indigenous health logics (e.g., spiritual purification). Instead of repackaging behavioral health practices, these two clinicians presented clients with an alternative, distinctively Native healing tradition that approximated the departure from the clinical care-as-usual imagined in abstract talk of culture during interviews.

## Discussion

In summary, asking clinicians about culture and clinical practice in the abstract did not closely reflect what was observed in concrete descriptions and demonstrations of day-to-day clinical practice. Whereas clinicians described dual engagement in a sociopolitical project of cultural reconnection and an intrapersonal project of self-discovery in the semistructured interviews, prolonged observation of day-to-day clinical practice revealed the latter, more professionally familiar project to be exceedingly dominant. Rather than engaging clients with precolonial cultural forms, the clinic's therapeutic milieu was primarily organized for the delivery of high-quality behavioral health services with added symbols of Indigeneity to create a different, more appealing experience of therapy for clients. This sense of cultural difference was created by inviting clients to engage with a recognizable set of decontextualized symbols of Indigeneity during activities that facilitated standard, well-regarded clinical processes. Furthermore, these engagements with Native culture in therapy were structured by clinical handouts and functioned similarly for Native and non-Native clients alike. By locating interpretive authority over these symbols of Native culture in each client, clinicians were relieved of the responsibility to develop the knowledge, relationships, and experiences needed to offer instruction on meanings as understood in local Native communities. Smudging was an important exception to this pattern because clinicians did provide instruction on the meaning of this healing practice. However, few clinicians had the requisite experience and training to communicate the meanings associated with this activity as practiced in Native communities; thus, most clients received an array of hybrid explanations that blended elements of American Indian and behavioral health traditions (i.e., health terms, health logics).

This divergence between abstract talk about culture in formal semistructured interviews and concrete descriptions and demonstrations of day-to-day clinical practice was influenced by competing culture concepts. When speaking on culture and the clinic in the abstract, as representatives of an urban American Indian-serving organization, clinicians tended to structure thought within a pattern of culture talk familiar

to American Indian community settings (i.e., culture as tradition), which invoked a tacit understanding of culture as something embedded in the foundations of clinical knowledge, institutions, and practices. This contextually oriented culture talk justified, if not demanded, a major departure from clinical practice-as-usual, leading clinicians to think about the clinic's behavioral health services in terms of a more radical sociopolitical project of cultural revitalization (per cultural reconnection). However, in day-to-day practice, operating as clinical professionals tasked with alleviating clients' distress under structural constraints of community behavioral health, clinicians engaged in a more professionally familiar pattern of culture talk that accounted for human diversity in terms of a circumscribed set of intrapersonal differences easily accommodated in clinical practice (i.e., culture as group orientation). This reductionist mode of culture talk channeled clinician attention toward repackaging clinical practice to reflect a set of attitudes, beliefs, and values thought common to (urban) American Indians (e.g., holistic ideas of health). Ultimately, rather than clinicians' readily accessible abstract thoughts about culture and the clinic, clinical practice was instead described and demonstrated, in concrete terms, to be informed by tacit understandings of health and human diversity embedded in patterns of culture talk and circumstances surrounding community behavioral health that shaped clinician behavior.

Far from unique to the clinic observed, this discursive disjunction in culture talk is reflective of national trends in behavioral health where a vast literature on cultural repackaging claims participation in sociopolitical projects of resisting "White psychology" and a "melting pot" philosophy in the social services (Kohli, Huber, & Faul, 2010; Reynolds & Pope, 1991; Sue, Bingham, Porché-Burke, & Vasquez, 1999). However, by conceptualizing culture as a group orientation, which locates culture apart from established clinical knowledge, institutions, and practices, these efforts primarily function to extend the clinic's reach into new populations of service consumers (Adams et al., 2012). Gone (2009) raised concerns about such work in American Indian communities and, along with Shaw (2005) and Kirmayer (2011), implicated the underlying cultural essentialism in a perpetuation of colonial oppression by ex-

tending modern American cultural sensibilities, of which psychology and behavioral health are products, further into reticent communities around the world via some of their most vulnerable members: the clinically distressed. Until psychology and behavioral health fields reconsider limited views of rigor to advance research capable of countering cultural essentialism, clinical professionals will continue down the path of least resistance by repackaging what is professionally familiar to appear consistent with diverse experiences by adding mere symbols of cultural difference to the established substance of reigning knowledge and practice.

Paving this path of least resistance has been psychology's drive toward "hard" science status, which has inundated the discipline and related fields with essentializing frameworks for thinking about human diversity in terms of culture concepts amenable to procedurally rigorous research (i.e., controlled experiments, highly scrutinized measures, statistical analyses). Such concepts, like group orientation, enable accounts of diversity divorced from any particular actors, settings, or circumstances to represent emergent negotiations as fixed properties of culture that add to, rather than challenge, established knowledge, institutions, and practices. Such accounts further marginalize diversity research as pertaining to merely superficial deviations from established norms, and absent practical frameworks for thinking through culture as an emergent negotiation in applied settings (e.g., the clinic), behavioral health professionals interested in diversity issues are inclined toward divergent culture talk, drawing from outside their profession for concepts that frame clinical practice as responsive to the experiences and sociopolitical interests of marginalized groups while relying on the essentialist culture concepts that pervade psychological knowledge and clinical training to guide behavior in day-to-day clinical practice.

Overcoming this reliance on cultural essentialism will require practical frameworks for thinking through culture in the clinic in terms of cultural analyses that make visible the taken-for-granted and difficult-to-articulate conceptual schemes guiding behavior in the clinic setting and contextualize those observations historically and geographically. Qualitative attention to participant meanings in response to investigator questioning alone cannot ade-

quately illuminate how those meanings emerge from fluid negotiations shaped by nonrational factors and various circumstances. For example, had this project ended with our interview analysis, findings would have grossly misrepresented clinical practice due to having mistaken culture talk, which clinicians used to frame the clinic's services as dually informed by intrapersonal and sociopolitical projects, for culture itself, which organized clinician behavior around the more professionally familiar psychotherapeutic project of client self-discovery. Alongside participant meanings, then, cultural analyses represent nonrational factors as the primary motivators of most human behavior in natural settings. For example, our ethnographic findings illuminated how, in practice, clinician behavior was primarily motivated by structural circumstances of community behavioral health (e.g., federal funding constraints) and clinical tradition, specifically, the symbolically meaningful forms of personhood, wellness, and healing that draw many into clinical professions and are made salient in actual settings and circumstances of clinical practice (i.e., the clinic). Cultural analysis thus represents a practical framework that psychologists might employ with community partners to generate new knowledge with more accurate and actionable understandings of culture and human behavior in context.

Rigor in rendering a cultural analysis speaks to the ability of a project to represent structural influences over human behavior in vivid, well-contextualized pictures of the particular. Rather than procedural assurances of replicability designed for discovering natural laws, cultural analysis requires prolonged, exploratory engagement in natural settings with ethnographic attention to participant behavior to contextualize observations with thick description and nuanced interpretations dispelling of essentialist culture concepts. As an imperfect example, our 19-week study documented culture talk under different circumstances within one behavioral health clinic to clarify and intensely contextualize how clinicians engaged in and understood multiple aspects of clinical practice. As a result, two patterns of negotiating culture were found to be the primary organizers of clinician behavior and behavioral health services. Further, having conceptualized culture as an emergent negotiation, the focus of research extended beyond clinician meaning-making to structures

of community behavioral health and circumstances under which clinicians operated to ultimately point back to professional bodies of knowledge and fields of practice where behavior is similarly shaped by tacit assumptions and nonobvious circumstances, leading to regular misrepresentations of human behavior. For a more rigorous psychological science, the discipline's fixation on procedural assurances of replicability and exclusive prizing of general, decontextualized knowledge must make room for understandings of rigor as tied to specificity, contextualization, and vividness of representation in the production of richly situated knowledge. In response to fundamental questions in psychology of "What knowledge is worth producing?" and "What research should be supported to produce it?," this reconsideration of rigor would also prize prolonged, exploratory, and ethnographically engaged modes of inquiry as distinctly capable of rendering accurate and actionable understandings of human experience, development, and behavior—not as timeless, placeless, or law-like but shaped by nonapparent, fluid negotiations of culture and circumstance that surround settings of interest, like the behavioral health clinic.

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