



Conceptualizing culture in (global) mental health: Lessons from an urban American Indian behavioral health clinic

William E. Hartmann^{a,*}, Denise M. Saint Arnault^b, Joseph P. Gone^{c,d}

^a School of Interdisciplinary Arts and Sciences, University of Washington, Bothell, WA, USA

^b School of Nursing, University of Michigan, Ann Arbor, MI, USA

^c Department of Anthropology, Harvard University, Cambridge, MA, USA

^d Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA

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ABSTRACT

The movement for global mental health (GMH) has brought perennial questions about human diversity in mental health to the fore through heightened debates over if and how established knowledge, institutions, and practices should be altered for ethical and effective interventions with diverse peoples around the world. Kirmayer and Pedersen (2014) encouraged dialogue between GMH scholars and communities considered for intervention to address differences and concerns about colonialism. American Indian mental health offers an instructive site for global mental health inquiry to understand frameworks that might facilitate this desired dialogue. Here, we draw from a clinical ethnography in urban American Indian behavioral health conducted between September 2014 and February 2015 to glean insights into a popular response to these differences: Incorporating Indigenous cultural forms into clinical practice. Our findings highlight a predicament this response presents to mental health professionals. They can either eschew their clinical training and its cultural assumptions to take up new lives enabling their representation of Indigenous cultural forms, or they can hold onto their professional training and modify what is clinically familiar to appear culturally different. Rather than a purposeful decision, in the clinic contextual factors—tacit assumptions, clinic structures, and popular culture concepts—powerfully shaped clinical practice and reconfigured Indigenous cultural forms to support familiar clinical processes (e.g., treatment-planning). Although potentially therapeutic, culturally repackaged mental health practices are not the therapeutic alternatives called for by many Indigenous communities, and when advertised as such, risk harmful appropriations and misleading reticent people into participating in culturally prescriptive interventions. Lessons for global mental health point away from incorporating Indigenous cultural forms into clinical practice, which is likely to result in cultural repackaging, toward ethnographically-informed dialogue of differences to inform models for medical and epistemic pluralism providing interested communities more culturally commensurate mental health services alongside well-supported Indigenous therapeutic alternatives.

Conceptualizations of human diversity in health and medicine are instrumental in determining the nature and scope of expertise afforded to professional bodies of knowledge and fields of practice (Napier et al., 2014). Today, spurred in large part by theoretical advancements and professional advocacy of multicultural psychologists in the 1990s (Sue et al., 2009), “culture” has become the predominant conceptual and linguistic frame with which diversity issues are engaged. However, different conceptualizations of culture, or “culture concepts,” convey distinct meanings stemming from the culture term’s extended history of being taken up by different groups at different times and ascribed

distinct meanings in pursuit of divergent ends (see Williams, 1976).

Use of culture concepts to think and talk about human diversity and its implications for clinical knowledge and practice is not new to the health and medical professions. However, these issues have become especially acute in growing fields of global medicine and mental health (GMH) where clinical traditions travel with research teams to realize interventions intending to “improve services for individuals living with mental health problems and psychosocial disabilities across the globe” (www.globalmentalhealth.org). The ensuing debate taken up here pertains to if and how local community or population differences ought to

* Corresponding author. School of Interdisciplinary Arts and Sciences, University of Washington-Bothell, Box 358530, 18115 Campus Way NE, Bothell, WA, 98011, USA.

E-mail address: weh3@uw.edu (W.E. Hartmann).

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inform changes to conventional clinical practice in GMH. Our analysis weighs in on this debate and related concerns about colonialism in GMH using an ethnographic example from American Indian behavioral health to elucidate how contextual factors inform responses to local differences by mental health professionals and the predicament this creates for GMH.

As the movement for GMH has renewed attention to debates over the significance of local differences for effective and ethical interventions across the globe, culture concepts have competed to frame ensuing debates; most prominently, through competing arguments for cultural competence and evidence-based practice (see [Gone, 2015](#); [Kirmayer, 2012a](#)). Cultural competence advocates have invoked culture concepts that amplify the significance of human diversity to justify diversifying clinical practice based on idiographic knowledge of different life experiences from distinct social contexts (e.g., culture as a group orientation imbricated in local social histories). In opposition, evidence-based practice proponents have invoked culture concepts that diminish the significance of human diversity for clinical practice to increase its standardization based on established bodies of nomothetic knowledge (e.g., culture as unreflective habits amenable to change when presented with reason-based alternatives). Thus, while cultural competence advocates have often framed these debates by characterizing clinical research and practice as expressive of an “ethnocentric monoculturalism” and therefore in need of diversification (e.g., [Sue, 2001](#)), evidence-based practice advocates have represented culture apart from clinical activities as an individual client and population characteristic or preference to be considered alongside clinician expertise and practical concerns (e.g., cost-effectiveness) in implementing scientifically vetted interventions (e.g., [Baker et al., 2009](#)).

In sites of acute power inequity—such as GMH interventions that involve researchers and funding from the Global North mobilizing to intervene upon the bodies, minds, and social practices of communities in the Global South—these debates over local differences, culture, and professional mental health practice quickly raise concerns about colonialism ([Adams and Estrada-Villalta, 2017](#); [Lovell et al., 2019](#); [Whitley, 2015](#)). To avoid reproducing colonial power relations in GMH, [Kirmayer and Pedersen \(2014\)](#) advocated for collaborative research including local peoples in a “bidirectional exchange of knowledge, values, and perspectives” (p. 770) to better understand and respond to differences between local and professional mental health knowledge and practice. Yet to date, little guidance has been offered regarding effective forms and frameworks to facilitate the desired dialogue addressing local differences in the GMH literature and in community research partnerships.

While dialogue of culture and colonialism in GMH continues, much can be learned from Indigenous peoples in the United States and Canada as instructive parallel sites for GMH inquiry. Such parallels include that these Indigenous peoples’ encounters with the mental health professions have been colored by settler colonialism (especially through boarding school and forced adoption initiatives; see [Jacobs, 2009](#)), not unlike peoples in the Global South targeted for GMH interventions. Attention to these similarities is instructive because activism and scholarship have illuminated how culture concepts have functioned as tools of colonialism in framing Indigenous peoples’ differences from their Euro-American/Canadian counterparts in medicine and mental health (see [Gone, 2007](#); [Waldram, 2004](#)). From 19th century civilizing missions to contemporary health programs, culture concepts have framed Indigenous differences in ways that invited a series of progressive projects intending to socialize Indigenous peoples into Euro-American/Canadian ways of living ([Gone, 2008, 2009a, 2009b](#); [Jacobs, 2009](#); [Waldram et al., 2006](#)).

In turn, Indigenous peoples have resisted these misrepresentations through practices of refusal (i.e., rejecting professional mental health framings of Indigenous lives altogether, per [Simpson, 2017](#); e.g., [Gone, 2007](#)). Additionally, Indigenous negotiation of alternative culture concepts has sought to more advantageously frame differences from Euro-American norms. Beyond this, Indigenous communities have

exercised treaty rights to administer their own professional mental health services at the community level ([IHS, 2015](#)), and insisted upon more collaborative, community-engaged approaches to health research (e.g., [CIHR, 2013](#)). These arrangements supportive tribal self-determination and enable the kinds of agentic negotiation of professional mental health by Indigenous peoples as called for in GMH ([Bemme & D’Souza, 2014](#); [Jain and Orr, 2016](#); [Kirmayer and Pedersen, 2014](#)). Thus, having accrued experience in negotiating culture concepts and resisting colonialism in U.S. and Canadian mental health, there is much to learn from these efforts. Such attention would shed light on the promise and challenge of dialogue for understanding and responding to differences between Indigenous peoples and professional mental health knowledge and practice.

Echoing the GMH literature, culture concepts have framed much thought and talk of human diversity and local differences in U.S. mental health and American Indian communities. At their intersection, American Indian mental health, which is principally funded and organized through the federal Indian Health Service (see [Gone and Trimble, 2012](#)), multiple culture concepts draw meaning from community and professional settings to inform the services made available. Drawing from American Indian communities, where trans-tribal movements for empowerment à la “cultural revitalization” popularized the concept of *culture as tradition* (see [Nagel, 1996](#)), conceptualizing local differences as cultural differences resisted assimilation by demarcating a stark Indigenous/Western binary and justified incorporating traditional healing practices alongside conventional mental health practices to pursue American Indian conceptions of health and wellness. Most narrowly, responses to local differences organized by this culture concept have challenged top-down impositions of conventional mental health services by incorporating traditional healing practices into clinic settings or making them available through clinician referral to traditional healers in nearby communities ([Waldram et al., 2006](#); [Young and Smith, 1992](#)). Most expansively, often under the banner of “culture as cure” (see [Brady, 1995](#); [Green, 2010](#)), this culture concept has facilitated additional inclusions of everyday activities associated with American Indian community life into professional mental health services (e.g., bead work, tribal language lessons; see [Echo-Hawk, 2011](#); [French, 2004](#)).

Drawing from professional mental health settings where cultural competence advocates popularized the concept of *culture as group orientation* by reimagining mid-19th century anthropological theories of culture as personality of a nation (see [Wallace and Fogelson, 1961](#)), researchers codified sets of beliefs, values, and behaviors thought to distinguish minoritized groups from their Euro-American counterparts to inform mental health service improvements. While this work initially focused on U.S. census-defined ethnic and racial minority categories, including American Indians and Alaska Natives as a single category, subsequent efforts have expanded to elaborate orientations distinguishing additional minoritized groups (e.g., religious minorities; [Hollinger, 1995](#); [Sue et al., 2009](#)). In response to critiques of cultural essentialism (e.g., [Kirmayer, 2012b](#); [Shaw, 2005](#); [Taylor, 2003](#)), some cultural competence advocates turned to alternative culture concepts (e.g., “cultural safety,” per [Papps and Ramsden, 1996](#)) to advance more contextually oriented understandings of human diversity and local differences in mental health. However in settings like the U.S., the impacts of these newer conceptualizations pale in comparison to that of thinking about culture as a minority group orientation, which has infused clinical research and training with attention to characteristics, needs, and interests thought to distinguish minoritized groups (e.g., [Sue and Sue, 1990](#); [Weaver, 2004](#)). Rather than waning in influence, this culture concept continues to catalyze new initiatives in mental health, including the popular practice of adapting empirically supported interventions for minoritized groups (i.e., cultural adaptation per [Bernal and Domenech Rodríguez, 2012](#); and [Castro et al., 2010](#)).

American Indian mental health has been powerfully shaped by these two popular culture concepts, each offering a distinctive framework for understanding and responding to Indigenous community differences in

the organization and provision of professional mental health services. The group orientation concept has led to the proliferation of interventions tailored to reflect beliefs, values, and behaviors presumed common to American Indians (Greenfield and Venner, 2012), and the tradition concept has led many American Indian mental and behavioral health clinics to incorporate traditional community practices into service offerings (Gone, 2011; Pomerville and Gone, 2018). As one of few settings where issues of culture and local differences are at the forefront of thinking about mental health, and one where tribal communities can exert some influence over if and how health services are made available, American Indian mental and behavioral health settings are ideally positioned to offer valuable lessons about the promise and challenge of negotiating colonial power relations through dialogue of local difference; lessons of particular relevance to ongoing debates in GMH.

Yet, surprisingly little is known about mental health practice in these settings. In perhaps the most illuminating publication to date, Waldram (2008) compiled five ethnographically grounded case studies documenting models and meanings of healing in five behavioral health programs funded by the Aboriginal Healing Foundation to serve Indigenous communities across Canada. These case studies illustrated immense diversity among Indigenous clients seeking treatment from these behavioral health programs, identified the centrality of Indigenous identity work to healing processes, and highlighted the prevalence of service delivery models that were flexible, pragmatic, and eclectic in drawing from Indigenous and conventional behavioral health treatment models to meet individual client needs. As a primarily descriptive project aiming to generate detailed accounts of treatment activities and stakeholder perspectives at each site, the role of culture concepts in tacitly guiding the organization and delivery of these eclectically integrated therapeutic services can only be inferred from case study descriptions.

In one case study, for example, Waldram and colleagues documented client and therapist perspectives on healing at Building A Nation (BAN), a First Nations behavioral health clinic in Saskatoon, Canada. Clinical work there was characterized by the research team as involving conventional approaches to behavioral health embedded in an explicitly Indigenous context and ethos. Intervention and support services included an array of clinically familiar practices with added Indigenous symbolism and community practices that appeared to be informed by variably conceptualizing culture as a group orientation (e.g., a Medicine Wheel tool was used as a racial typology depicting Aboriginal people as distinctively spiritual and holistic) and as tradition (e.g., participation in cultural traditions indicated treatment effectiveness). These descriptions suggest a complex interplay between multiple culture concepts operating to influence different aspects of clinical care. However, closer ethnographic attention to how culture concepts and other non-apparent contextual factors influenced these integrations of therapeutic practice is needed for further insight into sociopolitical questions about agency in the organization and delivery of therapeutic services in Indigenous treatment settings and related tensions between Indigenous self-determination and the legacy of colonialism in American Indian mental health (Gone, 2011).

Thus, echoing calls for greater ethnographic inquiry in GMH (Jain and Orr, 2016; Kohrt and Mendenhall, 2015), lessons from American Indian mental health about negotiating colonial power relations through dialogues of local differences framed as cultural differences would benefit greatly from ethnographic work clarifying and contextualizing clinical practice with reference to non-apparent contextual factors, including culture concepts, that facilitate and constrain possibilities for organizing and delivering therapeutic services. To inform such lessons, we present a clinical ethnography of an urban American Indian behavioral health clinic. This clinical ethnography was developed with therapists at an IHS-funded community health organization serving American Indians and other underserved populations in a large Midwestern city in the U.S. Our research question was, "How does culture operate in the clinic to shape behavioral health services?" The goal for

this project was to paint a vivid picture of culture and clinical practice that disentangled the influences of post-hoc reasoning with culture concepts from the "culture of the clinic" itself (Gone, 2007) over behavioral health services.

1. Method

Data collection occurred over 19 weeks (beginning September 2014, ending February 2015) and encompassed all settings in the clinic, except client encounters. It focused on the clinic's five employed therapists as actors of greatest influence over the organization and delivery of therapeutic services while also including several clinical social work student trainees, as well as additional staff, administrators, a cultural aide that worked in the clinic, and a community elder involved in the clinic. All five therapists were clinical social workers (four female, one male; three Native, two non-Native; Mage = 34.6 years, SD = 3.97 years), and the behavioral health clinic was one of four departments in a larger health organization established through 1970s activism by and for members of the local multiracial American Indian community.

Importantly, professional behavioral health services added to the health and wellness options available to community members, and at the time of study, represented one of multiple therapeutic options available for community members to address hardship and pursue health and wellness at this health center and in the local American Indian community (e.g., ceremony). Issues of culture and local difference were at the forefront of thinking about community services here, including behavioral health services. Therefore, a common topic of discussion in the community health center and during regular meetings of its traditional teacher's council, which functioned as an advisory board for the health center. Of note, community members were connected primarily to Three Fires tribes (Ojibwe/Chippewa, Potawatomi), secondarily to Haudenosauni/Iroquois tribes (Mohawk, Oneida, Onondaga, Cayuga, Seneca), and thirdly to other tribes across North America (for more, see Hartmann, 2016).

Previously published findings from this work highlighted a "discursive disjunction" in how therapists thought and talked about culture in relation to clinical practice. Speaking in the abstract, as representatives of an American Indian health organization, therapists drew upon popular community frameworks for conceptualizing culture as tradition, something deeply embedded in the foundations of distinct American Indian and professional mental health therapeutic traditions. This mode of thinking and talking about local differences led therapists to pursue incorporating American Indian cultural forms into clinical practice to dramatically transform behavioral health services. However, in day-to-day clinical practice, as mental health professionals tasked with alleviating client distress and managing heavy caseloads, therapists drew upon the professionally familiar framework of group orientation to conceptualize culture as a circumscribed set of dispositional differences to be accommodated with minor adjustments to standard clinical practices and processes. Resultant behavioral health services reflected high quality clinical practices and processes that had been repackaged by adding decontextualized symbols of Indigeneity to create a more appealing experience of psychotherapy and support services for Native and non-Native clients alike (Hartmann et al., 2020).

The present analysis aims to elucidate mechanisms underlying this opaque phenomenon of *cultural repackaging* as a response to concerns about local differences. Rather than unique to the clinic observed, repackaging the clinically familiar as culturally different is an increasingly popular response to local differences in both U.S. mental health (Gone, 2009a; Shaw, 2005) and GMH (see Kirmayer and Swartz, 2014). Presenting evidence from this urban American Indian behavioral health clinical ethnography, we explain the cultural repackaging trend as a predictable product of value-laden tacit assumptions embedded in mental health training, the clinic structure, and popular culture concepts. This project was approved by the University of Michigan Institutional Review Board, and this manuscript was reviewed and approved

by the community health organization administration and provided for feedback from the therapists involved.

2. Findings

Findings illustrate how behavioral health services were informed by contextual factors common to many, if not most, clinical treatment settings: popular culture concepts, tacit beliefs embedded in clinical training, and the clinic structure. This, despite regular discussion of local differences in the health center and therapists' deeply held commitments to taking those differences seriously in their clinical work. First, by constructing local differences as cultural differences, two familiar culture concepts exerted influence within the clinic setting by pre-structuring thought and action related to clinical practice with urban American Indian clients, creating an unrecognized predicament for therapists tasked with alleviating client distress. Second, guided by value-laden tacit assumptions embedded in professional mental health training, therapists responded to this predicament by repackaging the clinically familiar as culturally different to offer a more appealing experience of psychotherapy and support services for clients. Lastly, the clinic structure constrained possible alternatives to this response of cultural repackaging through its organization around individual, one-on-one therapeutic encounters and its position within bureaucratic regulatory systems. These unapparent influences over clinical practice highlight the complexity of dialogue needed to respond to concerns about colonialism in American Indian and global mental health, and our analysis sheds light on this increasingly popular response of cultural repackaging in professional mental health to clarify its appeal and limitations.

2.1. Understanding local differences as cultural differences

In this community health center, the concept of culture as tradition featured prominently in framing discussions of American Indian differences from their Euro-American counterparts and predominant "Western" ideas and practices for health. Guided by an ethos of empowerment via cultural reclamation, American Indian traditions were frequently held up as vital for healthy living, and where possible, incorporated into health center services to make them "culturally-grounded." A prominent advertisement for the health center read: "Our approach integrates traditional Native American healing and spiritual practices with contemporary western medicine," and although forms of integration varied program to program, local differences were consistently constructed as cultural differences between American Indian and professional health and medical traditions to explain various incorporations of American Indian cultural forms.

The behavioral health clinic was no different, describing its own integration of American Indian and professional mental health therapeutic traditions in the following manner:

[Our] Qualified Mental Health Professionals are highly trained and experienced therapists They function as guides along a path to wellbeing incorporating culturally based treatment methods with larger community supported approaches to nurture the mind, body, and spirit balance. -Clinic brochure

In step with the larger health center, local American Indian differences were interpreted within the framework of culture as tradition, and in response to community demands and their own personal and professional commitments to taking culture seriously, therapists aimed to break away from clinical practice-as-usual by "incorporating culturally-based treatment methods" and American Indian "community supported approaches" into their behavioral health services.

This shared commitment and organizing principle for behavioral health services was messaged widely and consistently via clinic brochures, the health organization website, and therapist descriptions of

the clinic and its services. For example, while presenting to an external audience of social work professionals, two therapists—Blair and Charlie—began by characterizing the "integration of culture into social work practice" as "essential" for working with American Indian clients and highlighted the clinic's use of "sacred medicines" and "traditional teachings" in therapy to illustrate the desired reconfiguration of behavioral health services as "culturally responsive."

Engaging clients around sacred medicines and traditional teachings in therapy were principal strategies for incorporating American Indian culture into this clinic. Sacred medicines were introduced to clients early and typically used once each therapy session to smudge (a brief practice familiar to many American Indian peoples that varies in form but often involves the burning of sacred plant medicines). Traditional teachings were represented in the clinic's treatment-planning process, which typically occurred immediately after addressing any pressing client crises (e.g., eviction), and rarely represented elsewhere in therapy except to revisit clients' treatment goals. However, in the clinic setting these cultural forms, sacred medicines (cedar, sage, sweet grass, and tobacco) and traditional teachings (Medicine Wheel and Seven Grandfather-Grandmother teachings), took on more professionally familiar meanings and were reconfigured as clinical tools for use by therapists in facilitating familiar clinical processes.

2.2. Incorporating traditional teachings

Although behavioral health services were consistently described as incorporating traditional teachings, none of the clinic's five employed therapists were recognized within any American Indian community as sources for such instruction. All five therapists nonetheless felt comfortable and confident engaging with clients around these teachings due to professional commitments to what was described as a "client-centered" approach to clinical work (see [Kirschenbaum and Jourdan, 2005](#)). Variably characterized as "meeting the client where they're at," "letting the client lead," and "making the client the expert," this client-centered approach was thought to resonate with non-directive Indigenous didactic practices, had been prescribed for use with American Indians in the mental health literature (e.g., [Bichsel and Mallinckrodt, 2001](#); [Thomas and Bellefeuille, 2006](#)), and has long been an ethical cornerstone of mental health care in order to reserve clients the ultimate authority in making meaning of their life experiences.

In this clinic, clients' interpretive authority had been extended to include their experience of these teachings. Charlie explained:

I don't think when you've got this one teaching it has to be defined this one way. It's about really understanding what that [teaching] is. Not just what it means to you, but what it means to the client. And not to enforce—I think that's one thing about being a social worker, not enforcing and inflicting your own ideas of culture on the client or person you're working with. So I do feel that is important, and I would say everybody is on the same page with that.

Charlie made clear that "really understanding" these teachings required therapists to bracket "what it means to you" and allow clients to make their own, personal interpretations. This was not only viewed as "important," but failure to do so was characterized as a violent act of "enforcing and inflicting your own ideas of culture on the client."

In this way, Indigenous claims to proprietary authority over Indigenous cultural forms (e.g., traditional teachings) were read within a framework of clinical concerns about therapists imposing their beliefs and values on vulnerable clients and therefore rejected in favor of a professionally familiar focus on individual client meaning making. This professional commitment to client-centered clinical practice thus prohibited attention to contemporary American Indian community meanings and contextual information in therapy. Instead, therapists introduced teachings through two one-page worksheets used to assist clients in developing their own interpretations through reflection and

introspection regarding “your strengths, abilities, goals, plans, hopes, interests, preferences, and natural supports”, the “reason for [your] wellness journey”, and “short term” and “long term goals” for treatment (see [Appendix A](#)).

Ellis role-played introducing the Seven Grandfather-Grandmother teachings to a new client:

‘As you might know, we are a Native clinic, and our treatment can be informed by culture and customs and specific Native teachings. There are Seven Grandfather teachings that are specifically important to this region ...’ And then we often read this together [points to pamphlet], ‘Although these are Native traditions, many clients feel even if they’re not Native that these translate, and they connect with as well.’

In this way, clients—Native and non-Native, alike—were invited to “connect with” teachings to develop their own, novel interpretations through processes of introspection and reflection while clarifying treatment goals and a treatment plan. When clients struggled to ascribe personal meaning to teachings in this process, therapists often introduced a pamphlet (see [Appendix B](#)) and offered verbal encouragements with reassurances of the clients’ interpretive authority. This pamphlet offered little information about the teachings beyond noting their Ojibwe origin and characterizing them as part of a “take care of Mother Earth and each other” mandate.

Rather than direct client attention outward toward contextual information or external perspectives that might assist them in making meanings that approximate those circulating in Ojibwe communities, therapists encouraged clients to look inward for meaning. If speaking the seven terms associated with these teachings aloud while reading the pamphlet did not facilitate client comfort in ascribing personal meaning to each teaching, therapists described sharing examples of potential answers developed by previous clients. For example, Dani recalled responding to a client struggling to make sense of “Truth” and “Honesty” teachings:

‘Well, what do you think the difference is?’ because that’s really all that matters. And if I feel like they want it, I’ll say ‘Well some people think Truth is more this and Honesty is more this, but however you view these concepts.’

Ascribing personal meaning to teachings did not always come easily to clients, and in such cases, therapists offered similar reassurances of “however you view these concepts” is “all that really matters” to underscore clients’ interpretive authority and encourage reflection and introspection.

Whereas commitments to being client-centered prohibited attention to American Indian community meanings and contextual information in behavioral health treatment, all but one therapist described negotiating, and at times challenging, client interpretations of these teachings based on their own authority as mental health professionals. Therapists described challenging interpretations deemed potentially harmful or unhealthy, noting that subtle nudges occurred “almost every single time” during these activities (e.g., Ellis: “that’s not being a failure, that actually takes courage in some ways”). More direct challenges, though, were said to be rare. Dani elaborated on this commonly felt need to balance client-centeredness with ensuring the treatment plan was “in line with what they’re here to work on”:

Yeah, there’s been times when I’ve had to like rephrase it ... like, ‘I wonder if you could look at it in a different way?’ I have had, for example, ‘I’d better not talk back to my partner because I better respect him.’ So there are times when I’m seeing ... maladaptive behaviors or patterns. I’ll ask them to rethink about it in a different way. And if they really feel that ... and that’s what they want to write down, we’ll have a conversation. But that wouldn’t translate into the treatment plan.

In this example, a client’s interpretation of the Seven Grandfather-Grandmother teaching on “Respect” as “not talk back to my partner” was challenged based on the therapist’s authority as a mental health professional over what is healthy or adaptive for clients. This knowledge, Dani explained, was also informed by the clinic’s intake procedure, which shed light on “maladaptive behaviors or patterns” and the client’s reason for coming to therapy. For Dani and all but one of their therapist colleagues, this exercise was about negotiating the client’s interpretive authority with therapists’ own understandings of what is healthy or adaptive (i.e., “meeting people where they’re at, but if I’m seeing major maladaptive behaviors illustrated in this [exercise] I’m going to talk about it”). In this way, confronted with client interpretations viewed as maladaptive, therapists deployed clinical re-statements to “rephrase” client interpretations, solicited alternative interpretations from the client (e.g., “I wonder if you could look at it another way?”), and when necessary, recorded the client’s problematic interpretations only to move on and prevent it from influencing subsequent treatment activities.

2.3. Incorporating sacred medicines

In contrast to therapists’ treatment of traditional teachings where interpretive authority was largely reserved for clients, therapists readily assumed that authority to explain the use of sacred medicines in smudging to clients. Smudging was a conspicuous feature of the clinic and its behavioral health services. All four plant medicines were prominently displayed throughout the clinic, the smell of burnt sage was often in the air, and smudging occurred prior to all staff meetings and in therapy with clients unless a client expressed discomfort or had respiratory health issues. In therapy, this practice was introduced to clients early, typically in the first session, prompted by the therapist or client referencing the plant medicines conspicuously placed on a side table in each therapy room. Therapists described addressing the presence of these plant medicines by inquiring about the client’s familiarity with this practice and briefly explaining the what, how, and why of smudging in therapy, which was followed by an invitation: “Would you be willing to smudge?” or “Would you be willing to try it?”

The clinic’s cultural aide described smudging as the topic most inquired about by therapists and had previously offered a version of the following explanation to each:

I put all four medicines in when I prepare smudge because it was one of my teachings that when we’re smudging we’re not only purifying ourselves, we put tobacco in for our prayers, and then the sage is for purification. The sweet grass is for tears, good thoughts, a reminder of our mother, that’s that smell. And the cedar can be for protection. So that’s what I put all of them in there because in my understanding when we’re smudging we’re doing all those things For the most part we talk about why we were given those, not a lot detail details. I never notice I need to go into the big huge stories about them ... but mainly just their roles, what they do, and why we use them.

In addition to clarifying that “huge stories” and “detail details” were not pertinent to therapists’ use of these sacred medicines in smudging with clients, the cultural aide explained the “roles, what they do, and why we use them” for each plant medicine. In doing so, the aide located interpretive authority in “my teachings,” not individual clients, and in place of clinically familiar intrapersonal mechanisms of healing (e.g., insight, adaptive thoughts, behavior change), the aide described the medicines themselves facilitating healing via “protection” and “purification.”

Therapists offered similarly explicit instruction on this practice to clients, however, the meanings they ascribed to it varied. Common explanations for “why we smudge” entailed building the therapeutic alliance, creating a routine for children, calming racing thoughts, helping clients cope with distress, alleviating depressed mood, clearing the air of

tion, “help [ing] people get on the same page,” cleansing a space of “bad energy,” and augmenting prayer in session. Thus, for therapists, smudging had multiple purposes and was introduced to clients in different contexts with different meanings variably drawn from American Indian community and professional mental health contexts (e.g., spiritual cleansing versus calming racing thoughts). Additionally, while the cultural aide forwarded the idea that all four medicines are to be used at once, this practice was never observed in the clinic. Three times sweet grass was used following emotionally distressing experiences (e.g., after a therapist broke down crying from work and life stress), and all other instances involved the use of sage alone. Furthermore, although the cultural aide and clinic materials detailed a specific protocol for interacting with the smoke from burnt plant medicines, therapists typically invited participants to “smudge however feels right.” Thus, smudging was put to multiple uses and introduced to clients with multiple, often intertwined explanatory models for its therapeutic effect, and importantly, these meanings were prescribed by therapists to clients, not elicited via client introspection.

3. Discussion

In response to concerns about cultural difference, this behavioral health clinic, like many GMH initiatives, set out to incorporate Indigenous cultural forms into clinical practice. However, in the clinic setting, these cultural forms—traditional teachings and sacred medicines—were ascribed new, clinically-familiar meanings and purposes. Represented by therapists operating within a framework of client-centered clinical practice, traditional teachings were reconfigured as decontextualized symbols of Indigeneity used to facilitate client reflection and introspection regarding personal strengths, hardship, and possibilities for healing through therapy. This emphasis on client strengths rather than deficits reflected the highly-regarded, but professionally-familiar, therapeutic disposition known as a “strengths-based approach” to clinical assessment and psychotherapy (see Graybeal, 2001), and while attending to multiple dimensions of hardship and healing (i.e., mind, body, spirit or mental, physical, emotional, spiritual) would likely result in more holistic understandings of health than popular emphases on maladaptive thoughts and behaviors alone, fostering client reflection and introspection is also a standard psychotherapy process (see Kirmayer, 2007). Thus, rather than making a substantive departure from professional mental health practice as imagined in abstract, therapists were engaging clients in high-quality clinical practices and processes with added symbols of Indigeneity that created a different, perhaps more appealing, experience of psychotherapy and support services.

3.1. Contextual factors

Despite considerable discussion of culture and local differences at this community health center, clinical practice was most powerfully shaped by tacit assumptions, the clinic structure, and popular culture concepts (i.e., non-apparent contextual factors). First and foremost, the task of representing traditional American Indian cultural forms in clinical practice fell to therapists who, given their training in mental health—a product of many modern American cultural sensibilities (e.g., client-centeredness expressive of American individualism; see Howe, 1994; Rose, 1996)—were in an unrecognized predicament shared by many mental health professionals working with populations underrepresented in mental health research. Therapists could eschew their mental health training and its underlying assumptions about self, health, and healing to represent Indigenous cultural forms, like traditional teachings, or they could hold onto their clinical training and make efforts to frame, tailor, and tweak what is professionally familiar to appear more reflective of and responsive to Indigenous interests, values, and characteristics.

Although undefined, a path toward representing traditional American Indian cultural forms might require therapists to be members of a

local tribe, involved in traditional societies, receive decades of training by respected community figures, and for some healing practices, acquire power from sacred lands and other-than-human persons (for an example of power acquisition, see Hallowell, 1975); little of which can be reasonably expected from a group of therapists whose own cultural proclivities led them to pursue careers in mental health. Given the unlikely prospect of therapists adopting new lives immersed in American Indian community practices and healing traditions, and finding ways to represent those practices in therapy with clients, it should be unsurprising that therapists in this clinic—like their clinical counterparts across Indian Country (see Gone, 2011; Waldram, 2004)—held onto their clinical training and channeled enthusiasm for taking culture seriously toward repackaging professionally-familiar mental health knowledge, practices, and the clinic itself as culturally different.

Alongside value-laden tacit assumptions embedded in mental health training and made salient while providing one-on-one psychotherapy and support services to distressed clients, the clinic and its schedule of back-to-back hourly individual therapy sessions also constrained possibilities for incorporating Indigenous cultural forms into the clinic. Indeed, few cultural forms are amenable to the clinic setting and schedule, and therefore most social practices were passed over in favor of brief activities, like smudging, or creatively reconfigured to fit easily into therapy sessions. Traditional teachings, which outside the clinic would be tied to detailed protocols and particular places, times, and people, were reconfigured as two activities organized in worksheets used by therapists to co-create treatment plans with clients.

Smudging with sage was similarly disassociated from any specific American Indian people or community practice (i.e., smudge “however feels right”) for use by any therapists with all clients. Unlike traditional teachings, which had been removed of any teaching to fit unobtrusively into therapy sessions, therapists were comfortable explaining smudging to clients. Although most clients received a blend of professional mental health and American Indian community explanations, two therapists familiar with this practice outside the clinic setting demonstrated the potential for smudging and similarly brief community practices to be incorporated into therapy without replacing community meanings with clinical explanations. However, in accounting for only a few minutes of each hour-long therapy session, this approach may be limited, and on its own risks positioning such practices as merely performative and potentially misleading reticent clients and communities.

Finally, having constructed local differences as cultural differences between American Indians and mental health professions, popular culture concepts both facilitated and constrained resultant understandings and actions. Thinking in terms of culture as tradition led therapists to attempt incorporating traditional American Indian cultural forms relevant to health and healing into therapy with clients. This was part of an ambitious sociopolitical project intended to ameliorate distress from cultural disconnection by reconnecting clients to cultural forms lost due to Euro-American colonial violence (Hartmann et al., 2020). However, within the clinic setting these ambitions were reimaged with the professionally familiar culture as group orientation concept, which re-focused therapist attention on tailoring high-quality clinical practices and processes to better reflect the characteristics, needs, and interests thought common to their urban American Indian clientele. The clinic’s treatment-planning process, for example, was tailored by adding recognizable symbols of Indigeneity (e.g., the Medicine Wheel, eagle feather images) to a well-regarded approach to providing psychotherapy and support services.

Thus, despite informing a different, perhaps more appealing, experience of behavioral health care and encouraging interested clients to further explore American Indian culture and community outside the clinic setting, neither culture concept structured thinking about local differences and professional mental health practices in ways that produced viable Indigenous therapeutic alternatives to conventional, high-quality behavioral health care for American Indian individuals and communities. Importantly, these culturally repackaged behavioral

health services may have better reflected the therapeutic preferences of many, perhaps a majority of Native and non-Native clients seeking treatment here. Although client experiences of therapy fell beyond the scope of our study, which stands as an important limitation to our work, this analysis raises an important question about possible tensions between the interests of individual clients in a compelling therapeutic experience and the interests of Indigenous peoples in resisting harmful appropriations in service of cultural continuity and self-determination.

3.2. American Indian mental health

Concerns about human diversity and local differences in American Indian mental health are often contextualized and underscored with reference to Euro-American settler-colonialism, which has regularly enlisted the help of medical and health professions to replace Indigenous cultural forms with Euro-American norms (Gone, 2008; Waldram, 2004; Waldram et al., 2006). Yet, rather than generate Indigenous therapeutic alternatives, incorporating American Indian cultural forms into clinical practice appears limited to repackaging the clinically familiar as culturally different to make conventional mental health services more appealing. Increased appeal is certainly desirable in many respects, particularly for community members interested in utilizing mental health services. However, when those services are presented as culturally different, this cultural repackaging may mislead reticent individuals and communities into participating in otherwise conventional mental health services that expand, rather than challenge, the role of psychotherapy in socializing Indigenous peoples into forms of lived experience infused with Euro-American cultural sensibilities (Gone, 2009b; see Kirmayer, 2007).

Greater institutional recognition of these limits to incorporating culture into the clinic might instead lead mental health professionals to focus on assessing the “cultural commensurability” (Wendt and Gone, 2012) of established practices to provide those most commensurate with community norms and individual preferences. Indigenous therapeutic alternatives can then be left to respected figures in local American Indian communities to better ensure appropriate representation. Examples of such alternatives include the Yu’pik People Awakening Project (see Allen et al., 2014), the Blackfeet Indian Culture Camp (see Gone and Calf Looking, 2015), and the Urban American Indian Traditional Spirituality Program (see Gone et al., 2020). Notably, all three extra-clinical interventions ultimately replaced formal mental health services and service-providers with Indigenous community figures leveraging local knowledge and practices as resources to pursue self-determined forms of health and wellness outside the clinic setting.

While provocative integrations of American Indian community and professional mental health traditions have been elaborated (e.g., Duran, 2006), the outsized role of non-apparent contextual factors shaping therapist behavior in clinic settings cautions against efforts to transform clinical practice through incorporating Indigenous cultural forms. Instead, identifying more culturally commensurate mental health practices would allow therapists to deliver high-quality clinical care based on their professional training while supporting interested clients in connecting with American Indian community resources outside the clinic setting. To support community referrals, clinic administrators could maintain good relations with local community groups and draw upon local resources to organize extra-clinical programming to meet community interests (e.g., Gone et al., 2020). By reserving representational responsibility and interpretive authority for respected community figures, mental health professionals can avoid harmful appropriations of American Indian culture and better address concerns about colonialism

in mental health by positioning established interventions alongside well-supported Indigenous therapeutic alternatives in a model of medical and epistemic pluralism for mental health research and practice (per Kirmayer, 2012a, 2012b).

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Despite their differences, American Indians and many peoples targeted for GMH intervention share common concerns about colonialism in the proselytization of professional mental health practices and their underlying cultural sensibilities; concerns heightened where local differences are downplayed as superficial and easily accommodated with minor modifications (Gone, 2009a; Summerfield, 2012). Although incorporating Indigenous cultural forms into clinical practice is a common response to local differences by researchers in both literatures, where mental health professionals, clinic institutions, and popular culture concepts are involved, such efforts are likely to result in repackaging the clinically familiar as culturally different. Rather than address concerns about colonialism, this response generates performative rather than substantive responses to human diversity and works to extend, rather than challenge, the reach of the clinical establishment into reticent populations. Instead of incorporating Indigenous cultural forms into clinical practice, GMH researchers—like their counterparts in American Indian mental health—can explore if and how professional mental health research and clinical practices might fit within collaborative models for medical and epistemic pluralism organized to clarify and support Indigenous peoples’ self-determined health and wellness goals rather than convert them to Western psychosocial norms.

Achieving such clarity for Kirmayer and Pedersen’s (2014) proposed dialogue of local differences across the distinct “ways of knowing” that undergird professional and community framings of health and wellness is complicated by the outsized influence of non-apparent contextual factors shaping clinician behavior in mental health settings. As illustrated in the urban American Indian behavioral health clinic observed, ample discussion of culture and local differences by therapists, clinic administrators, and health organization advisors informed abstract ambitions but bore limited influence over activities within the clinic setting. This finding suggests notions of dialogue as researcher-community discussion are overly simplistic, and it underscores the potential contributions of ethnographic inquiry to elucidating symbolically-meaningful, context-bound influences that can better inform dialogue of local differences and human diversity in community research partnerships and GMH. Culture concepts have proven useful tools for exploring how such contextual influences are rooted in “divergent rationalities” (Shweder, 1986), and for American Indian peoples, culture concepts have been taken up to resist misrepresentations and top-down impositions by the mental health establishment. However, as illustrated by this clinical ethnography, culture concepts can also be barriers to conceptual clarity and informed dialogue due to their pull for essentialism and generalization (see also Prussing, 2011; Shaw, 2005). Thus, productive dialogue will require critical reflection on the construction of local difference as cultural difference and the promotion of culture concepts that encourage more nuanced, particularistic representations of influential formations in GMH and the social life of communities inviting of GMH intervention.

4. Conclusion

The movement for GMH has been fueled by humanitarian desires to alleviate suffering around the world through the promotion of

professional mental health practices, however as American Indian experiences with health and medical professions attest, well-intentioned interventions can cause immense harm by eroding cultural foundations upon which Indigenous community well-being is organized and depends (Chandler and Lalonde, 1998). This colonial violence is the product of misrepresenting Indigenous peoples' lives and their differences from Europeans and Euro-Americans, which results in misdirected and often harmful interventions. To avoid such outcomes in GMH, Kirmayer and Pedersen (2014) called for a "bidirectional exchange of knowledge, values, and perspectives" (p. 70) between GMH scholars and diverse peoples around the world with whom interventions are considered. This clinical ethnography aimed to elucidate one popular response to local differences in GMH and American Indian mental health—incorporating Indigenous cultural forms into clinical practice—by describing such efforts in an urban American Indian behavioral health clinic. There, discussions of local differences constructed as cultural differences directed therapist efforts toward incorporating traditional teachings and sacred medicines into clinical practice, however, non-apparent contextual factors tied to the clinic setting reconfigured these cultural forms to facilitate standard clinical processes (e.g., reflection and introspection).

Where similar factors are present in GMH initiatives (i.e., mental health professionals, clinic institutions, popular culture concepts), efforts to resolve differences with diverse peoples by incorporating Indigenous cultural forms are likely to result similarly. While potentially therapeutic, culturally repackaged mental health practices potentiate harmful appropriations of Indigenous cultural forms and can mislead

reticent individuals and populations into participating in culturally-prescriptive clinical practices. Furthermore, the influence of contextual factors over professional mental health practice suggests researcher-community discussion alone may be insufficient to inform the desired dialogue of difference. Ethnographic inquiry can help to make visible influential formations in GMH and Indigenous community life to inform dialogues of difference that can better support Indigenous peoples' self-determination in domains of health and wellness. Where Indigenous communities are interested in professional mental health interventions, rather than attempt transforming them by incorporating Indigenous cultural forms, we encourage developing models of medical and epistemic pluralism to offer more culturally commensurate forms of mental health care advertised as such alongside well-supported Indigenous therapeutic alternatives.

Credit statement

William E. Hartmann: Conceptualization, Methodology, Formal Analysis, Investigation, Writing-Original Draft, Funding Acquisition. **Denise M. Saint Arnault:** Methodology, Supervision, Writing- reviewing and editing. **Joseph P. Gone:** Conceptualization, Supervision, Writing- reviewing and editing.

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Appendix A

Two-Page Treatment-Planning Tool

Treatment Plan

Reason for Wellness Journey?

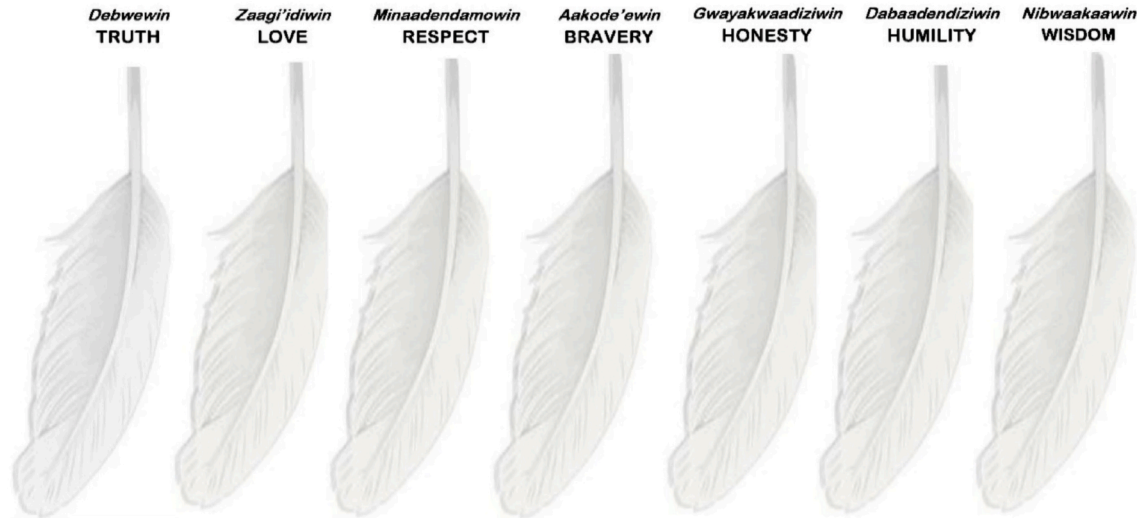
Your GOALS:
 On a scale of 1-5 where do you feel you are right now?
 On a scale of 1-5 where do you feel you would like to be in 90-days?

| GOALS | 90 Days | | | | |
|-------|---------|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| SGT 1 | | | | | |
| SGT 2 | | | | | |
| SGT 3 | | | | | |
| LGT 1 | | | | | |
| LGT 1 | | | | | |

Client Signature _____ ISP Date _____
 QMHP Signature _____ ISP Date _____
 Reviewed by _____ Review Date _____

Seven Grandfather Teachings Worksheet

Please list or describe which or how many of the Seven Grandfather Teachings represent your strengths, abilities, goals, plans, hopes, interests, preferences, and natural supports.



Appendix B

Seven Grandfather Pamphlet

Seven Grandfather Teachings

We have to take care of *Aki* (Mother Earth) or we will not have a home. We must all share in this responsibility. We need to make sure that Mother Earth and everything the Creator gave her will always be here for future generations. Each morning let us remember to greet our Grandmothers and Grandfathers whose spirits are in the many glories that surround us. They taught us, as they had been taught by their elders, how to take care of Mother Earth and each other.

We are straying away from the Teachings given to us. Our young people do not pray and give thanksgiving. We need to know the Teachings of our Grandmothers and Grandfathers to give us direction and balance. Especially our leaders who are young; they need to listen and learn. We need their participation.

To take care of Mother Earth and the community of life, we need to remember the Teachings of the First Elder. The First Elder gave us the gifts of knowledge that he received from the Seven Grandfathers when he was a



little boy. Each Grandfather gave him a great gift. One gave him the gift of **NIBWAAKAAWIN (Wisdom)**, and he learned to use that wisdom for his people.

Another gave the gift of **ZAAGIDWIN (Love)**, so that he would love his brother and sister and share with them.



The third Grandfather offered the gift of **MANAADJITOWAAWIN (Respect)**, so that he would give respect to everyone, all human beings and all things created.

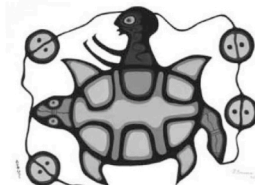


AAKODEWIN (Bravery) was the next gift, the courage to do things even in the most difficult of times.

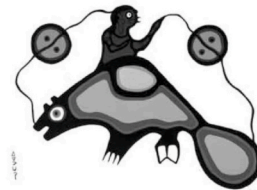
A fifth Grandfather gave the boy **GWEKOWAADIZIWIN (Honesty)**, so that he would be honest in every action and provide good feelings in his heart.



Another Grandfather offered **DIBAADENDIZOWIN (Humility)**, to teach the boy to know that he was equal to everyone else, no better or no less.



The last gift that was given to the boy was **DEBWEWIN (Truth)**. The Grandfather said, "Be true in everything that you do. Be true to yourself and true to your people. Always speak the truth."



The Grandfathers told him, "Each of these Teachings must be used with the rest. You can not have **WISDOM** without **LOVE, RESPECT, BRAVERY, HONESTY, HUMILITY, and TRUTH**. You can not be honest if you use only one or two of the Teachings, and to leave out one is to embrace the opposite of what the Teaching is."

We should all try to live by the Seven Grandfather Teachings. Sometimes it may be hard to apply all of them daily, but we must try. If we don't practice honesty, we cheat. If we don't practice truth, we will lie. We must go back to the knowledge that the Seven Grandfathers taught the First Elder, who then passed the Teachings on to the next generation, and so on.

The Seven Grandfather Teachings will remind us how to treat one another and our children. Each of us is responsible for taking care of the children and of Mother Earth. The children are the ones who must care for Mother Earth tomorrow, and for the generations to come.

- Author Unknown

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