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Cultural Pragmatism: In search of alternative thinking about cultural competence in mental health

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Abstract

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

Keywords

cultural competence; medical anthropology; multicultural psychology; epistemology; philosophy

1. Introduction

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

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

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

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

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

& Garro, 2006; Lopez et al., 2020), and emphasizing the provider's orientation to how cultural dynamics between patient and provider interact to cocreate a relational experience (Davis & DeBlaere et al., 2018). Cultural process models attend to the dynamic fluidity, intersectionality, and lived experience of cultural worldviews, and they complement the skills-based model to cultural competence.

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

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

2. Assumptions about truth in clinic: An interdisciplinary perspective

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

attentiveness to cultural dimensions of illness: clinical knowledge risks being set at odds with cultural experience.

This accounts for why some researchers in psychology observe that mental health's two mandates – to remain truth-seeking and to practice cultural competence – are “on the road to collision” (La Roche & Christopher, 2008; see also Hall, 2001; Kirmayer, 2005). Whereas some recent, more narrow understandings of evidence-based practice aim to provide treatment based on the best available research, cultural competence advocates argue for the importance of attending to human diversity.² As Joseph Gone (2015) writes, “The challenge is to take cultural variety very seriously... without either requiring a complete abandonment of clinical expertise (a trivialization of professional knowledge), or embracing merely superficial alterations in professional conventions toward otherwise familiar therapeutic objectives (a trivialization of cultural difference)” (p. 141).

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

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

²The *APA Presidential Task Force on Evidence-Based Practice* (APA, 2006) defines “evidence-based practice” as consisting of three parts: i) scientific evidence (both quantitative and qualitative); ii) clinical judgment; and iii) patient values. While this original definition is inclusive of clinical experience and cultural diversity, the latter two components tend to be overlooked in common understandings of evidence-based practice. This is further discussed in the concluding section to this article.

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

In this light, many anthropologists and a growing sector of psychologists argue it is mistaken to assume studies on culture will be predictive because our implicit definition of culture is mistaken: culture is not static or something a person upholds, “has,” or “is.” Instead, anthropologists suggest, culture is more accurately understood as a *dynamic process* that refers to peoples’ shared ways of understanding, interacting, and meaning-making in the world (see Geertz, 1973; Guarnaccia & Rodriguez, 1996; Llerena-Quinn, 2013; Kleinman & Benson, 2006; Santos et al., 2021). For this reason, it is argued that attempting to study culture through research on cultural categories is limited and there are growing calls to discontinue using the term “cultural competence” in lieu of alternative descriptions practice such as cultural humility.

A second critique against relying on a skills-based approach involves the inherent power relations that arise whenever culture is invoked. In an influential paper, Lila Abu-Lughod (1991) emphasizes the nature of culture as intersubjective and, for this reason, laden with power: any way one talks about culture, it is based upon the positionality of the researcher or clinician, and the other person being studied or treated. She writes that conclusions having to do with culture “enforce separations that inevitably carry a sense of hierarchy” (p. 138). For this reason, Abu-Lughod encourages moving beyond an understanding of culture that we might initially view as tentative and based on what Clifford and Marcus (1986/2010)

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

termed “partial truths” that never capture the full complexity of cultural experience, and instead suggests that we might also appreciate that any data purported to be about culture is also a “positioned truth,” based on specific power imbalances (p. 142; a similar point that interpreted in Levinas, 1969/1992). This critique highlights how gaining information about culture is inescapably steeped in power dynamics that reinstate distance between researcher and researched, and, for the same reason, provider and patient.

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

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

For example, the clinically useful Shifting Cultural Lenses model suggests that one behavioral indicator of engaging a process-oriented approach is the specific negotiation that occurs between patient and provider in their mutual understandings of illness (Santos et al., 2021, p. 129; see also: Lakes, Lopez & Garro, 2006; Lopez, 1997). Negotiation is similarly identified as a component in cultural humility (Tervalon & Murray-García, 1998) and the Multicultural Orientation Framework (Davis & DeBlaere et al., 2018). Yet negotiation implies the difference of two perspectives that may not be mutually intelligible and do not need to be mutually appreciated. Moreover, through the process of successful negotiation, two parties’ needs are met, but the resolution of their differences can result in one set of needs supersede the other. The emphasis on negotiation, it seems, implies a fundamental

difference between cultural experience and clinical expertise. When patient and provider engage in negotiation, there is risk of viewing clinical suggestions as something patients are expected to comply with, and viewing patients who do not comply as being at fault and jeopardizing treatment success. This is a concern given contemporary standards inspired by the Recovery Movement that seek to move beyond focusing on patient compliance with medical advice, and toward fostering patient self-determination and agency (Davidson, 2016; Corrigan et al., 2012).

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

3. Philosophy of science, philosophical pragmatism, and the relevance of pragmatism to clinical practice

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

At least retrospectively, arguments from the philosophy of science already began to raise awareness about the problem of differentiating truth from culture. In his illuminating article, “Is Psychological Science A-Cultural?” Joseph Gone (2011) reviews how, during the first half of the century, science was understood via positivism, a philosophical position that alleged that scientific knowledge was based on empirical verifiability. So, for example, we know depression increases risk of suicide, childhood trauma impacts psychological development, and eating disorders imperial physical wellbeing. These findings have been studied and tested, and we commonly believe something to be true because scientific studies have demonstrated them as such. Yet while this sensibility of acquiring the truth continues to dominate in clinical spheres, Gone reminds us that the idea of knowledge being “proven” was challenged already during the mid-20th century: Karl Popper (1959) argued that a scientific finding is never actually verified, but better understood as a tentative hypothesis

that has not yet been falsified; and Thomas Kuhn (1962) observed that scientific progress is rarely a sequential accumulation of facts, but often a result of rupturing paradigm shifts. Both arguments critiqued the underlying notion that the information we have gained from science is objective and transcendent of cultural variation, and instead argued that scientific findings are better conceived as cultural products, the best available information we have at a given time. In this vein, Gone argues that science, albeit uniquely contributing to knowledge by applying rational thinking to empirical evidence, “is never adopted or deployed outside of culturally constituted interests, objectives, and motivations” (pp. 238–9). For that reason, he concludes, psychology is inherently cultural. In the clinical fields, then, it would not be feasible to disentangle what is cultural from what is empirical.

What we come to know through scientific inquiry about culture is vital to clinical practice: empirical findings about improving diagnosis across cultural groups (Londono Tobon et al., 2021), adapting treatment for a given cultural population (Borrelli et al., 2010), recognizing social and structural determinants of distress (Metzl & Hansen, 2014) are just a few examples of why empirically attending to culture enhances clinical effectiveness. But there is a difference between saying that “culture is part of the social world and available to study,” an obvious point except for hard-lined skeptics who might question it, and another statement that “the truth about culture is part of the social world for us to know.” The latter point suggests that, with enough information, what we come to understand about culture will correspond to the objective, reality of the cultural world (see Rorty, 1989, p. 4). Yet insofar as we appreciate anthropological perspectives about culture as dynamic process, culture cannot be viewed as an objective and static object.

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

⁴William James (1907/2000) famously introduced pragmatism through a hypothetical thought experiment: imagine a man is circling a tree trying to see a squirrel who continuously escapes being seen. So, asks James, does the man go around the squirrel, or not? James introduces pragmatism by answering that there is no final answer – there isn’t a metaphysical truth underlying the question – because whichever answer one defends is rooted in its respective practical consequences, the “difference . . . it would practically make to anyone if this notion rather than that notion were true” (pp. 24–25). The same applies to questions in the clinic. In more contemporary work, Morton White (2002) imagines a case of indigestion, where the patient views indigestion as the cause of having eaten bad food, but a doctor understands indigestion due to underlying ulcers. Similar to James, White concludes that both understandings are true, based on different ways of understanding the world: “We see that they are answering different questions and so both can be speaking truthfully” (pp. 89–90). The pragmatic philosophers can be understood as critiquing the prioritization of one type of truth – a truth that transcends human experience or is objectively waiting to be discovered – because, at least when it comes to culture and human experience, there is no way to go beyond experience. Instead, as William James (1907/2000) wrote, “truth is made,” rather than found (p. 96; see also: Richardson, 2007; Rorty, 1989). And by this, James argued, what we believe to be true is an expression of how we have come to engage, pragmatically, with the world. Whether we say that the man really *is* going around the squirrel, or that the

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

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

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

patient has indigestion because of an ulcer, both answers say more about us and our particular ways of seeing and interacting with the world, rather than statements about the world’s underlying reality.

⁵To echo the writings of John Dewey (1958), what we consider to be true “is a knowing how rather than knowing that” (Brandom, 2011, p. 7).

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

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

4. Cultural Pragmatism: A preliminary model

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

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

Step 1. Identify what the patient holds to be true about illness.

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

Identifying what the patient holds to be true about illness offers a preliminary guardrail. It highlights how one's understanding about mental illness is not something to be challenged. So, cultural pragmatism begins by putting the patient first, asking exploratory questions such as: "*Why do you think you're experiencing the condition that brings you to treatment?*" "*Why are you seeking treatment now, as opposed to earlier in your life?*" or, "*How do you think I might best be able to address your needs?*" Additional guided and useful questions can be found in the DSM-5 Cultural Formulation Interview (APA, 2013; Lewis-Fernández et al., 2016). In general, these questions aim to recognize that the patient has their own understanding of illness, to convey respect for that point of view, and to invite further discussion of it.

Step 2. Explore the function of patient truth.

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

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

Step 3. Discuss the importance of patient concerns (and draw upon relevant cultural knowledge).

Cultural pragmatism encourages the use of previous knowledge gained about culture, and encourages a skills-based approach to acquiring cultural knowledge, but attends to patient experience first. After acquiring awareness about what is important for a patient, cultural pragmatism involves discussion between patient and provider about why it matters, both from a patient and provider point of view. This primarily involves a mutual recognition of the social parameters that defines a patient’s life. This is also the point at which clinicians might draw upon their own knowledge of a patient’s background and convey understanding of that worldview. It is useful to turn to previous training in cultural values and orientations (S. Sue et al., 2009), cultural conceptualizations of distress (Lewis-Fernández et al., 2003), as well as structural factors that constitute health disparities (Betancourt, Green, & Carillo, 2016; Metzl & Hansen, 2014), to name but a few examples. Each can prove to be helpful in promoting therapeutic dialogue and developing culturally relevant responses – to demonstrate prior awareness and appreciation of a patient’s cultural experience – but only to the extent that they resonate with the patient, with what functions and what is at stake to that person seeking treatment.

Step 4. Collaborate based upon clinical best practices.

Patients seek help from providers because of their presumed expertise in the field. Yet it is the clinician’s responsibility to honor this power dynamic and be cautious against substituting a cross-cultural collaborative strategy for one that purports to be acultural and objective. To this end, clinicians can inform patients about how they, as clinicians, are trained to understand distress, and what they know about how distress is optimally treated. They can discuss evidence-based approaches to recovery. Yet clinicians can simultaneously

translate their clinical knowledge to relate to the specific concerns of a patient's life. In this way, interventions shift from being presented as acultural toward engaging with the individual dimensions of experience.

When clinical skills and cultural knowledge are viewed pragmatically, providers move from negotiation of treatment strategies to collaboration. Collaboration involves both keeping focused on what matters to a patient and discussing how specific interventions might address those concerns. Drawing on the Recovery Movement, two additional mechanisms to promote collaboration involve: i) aiding the rational actor through clinical choices and shared decision-making, as well as ii) addressing environmental forces that are barriers to choice (Corrigan et al., 2012; see also: Metzl & Hansen, 2014).

Step 5. Situate subsequent interventions in patient language, including what is 'at stake.'

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

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

5. Concluding remarks

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

Cultural pragmatism attempts to resolve this dilemma. Through introducing a nuanced alternative to understanding what it means to say something is true in the clinical fields,

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

By employing the philosophical insights that the pragmatists offer about truth, this article has invited consideration for how the things people hold to be true can be alternatively appreciated as knowledge made rather than found. The pragmatists redefine what it means to say something is true – not based on generalization that convey a sense of acultural objectivity, but instead as expression of usefulness within a specific cultural setting. Pragmatism holds that truth is a perspective about what works. As such, the cultural pragmatism defended in this article maintains that patient truths are expressive of cultural functioning. Similarly, it holds that clinical truths are expressive of clinical usefulness. This perspective encourages appreciation for why divergent views about illness are important, and how attention to differences in knowledge can uphold the underlying ideals of cultural competence. Cultural pragmatism is not meant to replace previous competence models, but instead to serve as an epistemological foundation to appreciate the different perspectives individuals might introduce. In this way, cultural pragmatism aligns well with other efforts to prioritize pragmatism in efforts to speed up research translation (e.g., Glasgow, 2013), including implementation research focused on cultural adaptations of evidence-based interventions (Baumann et al., 2014; Cooper et al., 2020).

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

However jarring the pragmatic notion of truth might be – that it defies conventional notions and scientific authority – it is instructive to note that seeing truth as a matter of

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

contingency is congruent with other trends in the field. For example, the *APA Presidential Task Force on Evidence-Based Practice* (APA, 2006) defines “evidence-based practice” as consisting of three parts: i) scientific evidence (both quantitative and qualitative); ii) clinical judgment; and iii) patient values. In the spirit of the arguments made in this article, note that the second and third components are distinct from a strict empirical gathering of facts. Moreover, the policy explicitly cautions against prioritizing scientific evidence by overlooking clinical judgment and patient preference. Evidence-based practice recognizes that “evidence” about what works in mental health exceeds scientific inquiry and, further, that it involves intersubjective, cultural process (see also Jackson, 2015; Tolin et al., 2015).

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

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

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

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