transcultural psychiatry

"Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services

Mary-Jo DelVecchio Good
Harvard Medical School

Seth Donal Hannah
Massachusetts Institute of Technology

Abstract

The concept of culture as an analytic concept has increasingly been questioned by social scientists, just as health care institutions and clinicians have increasingly routinized concepts and uses of culture as means for improving the quality of care for racial and ethnic minorities. This paper examines this tension, asking whether it is possible to use cultural categories to develop evidenced-based practice guidelines in mental health services when these categories are challenged by the increasing hyperdiversity of patient populations and newer theories of culture that question direct connection between group-based social identities and cultural characteristics. Anthropologists have grown concerned about essentializing societies, yet unequal treatment on the basis of cultural, racial, or ethnic group membership is present in medicine and mental health care today. We argue that discussions of culture—patients' culture and the "culture of medicine"—should be sensitive to the risk of improper stereotypes, but should also be sensitive to the continuing significance of group-based discrimination and the myriad ways culture shapes clinical presentation, doctor–patient interactions, the illness experience, and the communication of symptoms. We recommend that mental health professionals consider the local contexts, with greater appreciation for the diversity of lived experience found among individual patients. This suggests a nuanced reliance on broad cultural categories of racial, ethnic, and national identities in evidence-based practice guidelines.

Corresponding authors:

Mary-Jo DelVecchio Good, Department of Global Health and Social Medicine, Harvard Medical School, 641 Huntington Ave., Boston, MA 02115, USA.
Seth Donal Hannah, Anthropology Program, Massachusetts Institute of Technology, 77 Massachusetts Ave., Cambridge, MA 02142, USA.
Email: maryjo_good@hms.harvard.edu and sdhannah@mit.edu

Mental health policies promote the training of clinicians in cultural competence, implying cultural knowledge of a specific kind. At the same time, mental health care is rooted in evidence-based practices, which are posed as universalistic in moral rhetoric. These concurrent trends capture a historically deep contest, tension, or dynamic within mental health services, policies, and practices, between universalism and cultural particularism. This paper examines this tension, asking whether it is possible to use cultural categories to develop evidence-based practice guidelines in mental health services at this moment when these categories are challenged by the increasing diversity of patient populations and newer theories of culture that question direct connection between group-based social identities and cultural characteristics. We begin with historical reflections on the use of culture in medicine and mental health care, followed by selective ethnographic data drawn from our research on contemporary mental health care.

Historical reflections

Why attend to culture in medicine and health care at this moment in time? For many decades, American medicine and its institutions of patient care have attended to the cultural distinctiveness of patients and carried out missions to redress inequalities in access to medical services for the poor, for ethnic and racial minorities, and for new immigrants and refugees. However, despite years of effort to institutionalize culturally sensitive and competent care and to reach out to serve and provide equitable care to minority patients, two highly consequential federal policy studies released in 2001 and 2002–2003 reported persistent inequalities and disparities in treatment by culture, race, and ethnicity over a wide range of psychiatric and medical specialties. *Mental Health: Culture, Race and Ethnicity* (Surgeon General, 2001) and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley, Stith, & Nelson, 2002–2003), found that unequal medical and psychiatric treatment cannot be explained by differences in access or by individual patient characteristics alone, thereby leading researchers and policy makers to seek explanations in subtle and complex psychological, social, and cultural processes in interactions between patients and their doctors and healthcare institutions (Smedley et al., 2002–2003; Surgeon General, 2001). The public discussions generated by these two policy debates on "culture counts" and "unequal treatment" remain vibrant and profoundly relevant in health policy and medical circles in contemporary contexts of increasingly complex cultural and demographic diversity.

The issues of universalism and cultural particularism and the tension between the poles of these two conceptual stances came to the fore with these reports, even

as the concept of culture came to have a newfound cachet in American medicine in the 21st century. In addition, debates about what constituted "evidence" highlighted the conceptions or ideological and cultural stances of those who were engaged in producing and responding to these reports (Chang, 2003; Chavez, 2003). The social milieu generating a new political dynamism in the meaning and importance of culture was at least in part related to the dramatic transformation in the demographic landscape of American society.[1] The "new" immigration over the past several decades has intensified American cultural diversity and increased complex formulations of racial and ethnic identities (Lee & Bean, 2010), bringing about what we have defined as the emergence of *cultural environments of hyperdiversity* (Hannah, 2011a, 2011b).

We framed our research with the overarching query "How does American medicine respond to cultural diversity, and does culture make a difference in American health care and in mental health care?" and sought to identify the various ways "culture" is used and given meaning in psychiatry and mental health care. Although our ethnographic studies were located in clinical settings in Greater Boston, we drew on broader literature to explore how ideas about culture, ethnicity, immigration, diversity, disparities, and inequalities are shaped *in* and *by* American medicine and psychiatry. How did these ideas influence clinical ideologies, form clinical practices, and design programs to deliver quality care to be culturally appropriate, sensitive, or competent? We also sought to understand the roles and meanings of culture from the perspective of clinicians and healthcare staff who treat patients from diverse cultural backgrounds and who find "culture" relevant in their daily clinical work, asking them to reflect not only on patient culture but on the culture of psychiatry and medicine and of their clinics, in other words, organizational culture.

Living inside and through these histories can lead to unexamined assumptions. In this decade long project, we explored continuities and innovations. What is different about this contemporary moment from so many decades ago when concepts about race, ethnicity, and patient culture were popular in the 1960s and used as the basis of establishing community clinics as part of President Johnson's agenda for The Great Society?[2] How does that history influence the way that doctors and clinics use culture concepts and think about how "culture counts" in organizing care in today's culturally diverse medical settings? To what extent does the language of cultural competence in contemporary medicine rely on ideas of these earlier eras, of coherent ethnic communities sharing coherent cultures?[3] How were changing demographics and the new immigration influencing "culture concepts" and to what extent were new meanings along with new experiences regarding patient and professional culture finding their way into the discourses, practices, and policies in mental health care and psychiatry (Suárez-Orozco, Suárez-Orozco, & Qin-Hilliard, 2005)? Fundamental to the decades of our research were basic questions about the dynamic changes in the culture of medicine and in particular the culture of psychiatry: How are the broad symbolic systems that support psychiatry and medicine and their subspecialties interacting with the fluid dynamic and

multivocal meanings of ethnicity, race, and culture that have evolved over the past two decades? An array of professional conceptions about culture, clinical practice, and therapeutic processes emerged. Amidst this diversity, a standardization of residency training and practice and of clinic goals was evident in policies on "cultural competence" and "disparities reduction" by race and ethnicity. In addition, an increase in interpreter services to address "language" needs was evident, in part in response to "the rule of law."

Shattering culture

The terms "shattering culture" and "cultural environments of hyperdiversity," or simply "hyperdiversity," emerged directly from our ethnographic investigations and observations. Hyperdiversity, a term used by many scholars to describe recent increases in diversity,[4] was further defined and theoretically developed by Seth Hannah (2008, 2011a, 2011b) while conducting fieldwork in clinical settings in Greater Boston. Like others, Hannah uses the term hyperdiversity to identify our nation's dynamic population transition to a complex and mosaic-like mix of national origin, ethnicity, race, immigration status, and nativity. Hannah also uses hyperdiversity to describe the growing multidimensionality of identity, pointing out that individuals often occupy multiple forms of identity at once and may contextually shift which form of identity is most important to them.[5] What is more, the exigencies of particular social settings may lead some forms of identity to gain salience while others become less important. Hannah argues that when many racial, ethnic, or national origin groups are present in a social setting, other forms of identity such as educational background, cultural interest, or (in medical settings) illness category are more likely to become prominent.

The term *shattering culture* (M.-J. D. Good et al., 2011) popped out from our analyses of interviews and observations. The book title names the uncertainty that arises in these cultural environments of hyperdiversity in which broad identity based indicators of cultural difference are often too blunt to capture current social and individual identities. The new immigration and the new ethnic-racial mix in younger generations of Americans and immigrants have shattered bounded communities and the cultural meanings of the old social categories of ethnicity and race, as cultural identities have increasingly become more complex, dynamic, fluid, and evolving.[6]

There is a gradual breaking apart of the census categories of the race and ethnicity pentad in a dynamic and ever evolving fashion. The system used recently by the U.S. Census Bureau and the National Institutes of Health (NIH) relies on four racial categories (White, Black, Asian, Native American) and one ethnic category (Hispanic/Latino) and has recently expanded to allow for mixed race identification and a fifth racial category (Native Hawaiian/Pacific Islander).[7] The ethno-racial blocs were introduced to the U.S. census as a way to capture the dominant social categories in the United States; yet, they have always been a subject of great political controversy and contestation, and imperfectly represent the local patterns of everyday identity (Hochschild & Powell, 2008).

In recent years, the strength of the pentad has been reinforced by epidemiology, health services, and politics as the recording of patient race and ethnicity has become central to efforts to reduce health disparities (Epstein, 2007; Hattam, 2005). Government data collection using the U.S. census pentad categories has been successful in documenting patterns of discrimination in housing, healthcare, and other socially influenced measures of wellbeing. Despite this success, demographic change, immigration, and social movements promoting mixed race identities have begun to once again destabilize the dominant modes of classification (Daniel, Kina, Dariotis, & Fojas, 2014; Hochschild, Weaver, & Burch, 2012). In 2000, the U.S. Census allowed respondents to choose more than one race, and the 2010 Census found that the number of individuals choosing mixed race grew faster than the number choosing a single racial category (U.S. Census, 2010). Thus, the certainty of these official categories used in health and other government policy research is "shattered," challenging their utility in the future.

The United States system of classification also reinforces the common conflation of race with ethnicity, as Hispanic/Latino is often treated as a distinct racial category in statistical reporting even though persons who identify as Hispanic/Latino are prompted to also choose a racial identification on the census. The conflation of race with ethnicity is particularly problematic when combined with considerations of cultural difference.[8] Many cultural competence programs associate cultural traits with ethnic group membership in an effort to teach health care providers about the cultural characteristics of their patients (Flores, Gee, & Kastner, 2000; Lo & Stacey, 2008; Vega, 2005). While it is clear that cultural diversity often covaries with racial and ethnic classifications, this may not always be the case. Cultural diversity can exist within ethnic groups as well, and there are other dimensions of culture (such as those deriving from class background or education) that do not cleanly match up with ethnic identity (Ford, 2008; Kim, Yang, Atkinson, Wolfe, & Hong, 2001). This led some respondents in our study to question the crude association of cultural traits to broad groups of patients. An interfaith chaplain who works with inpatient psychiatric patients stated, "I can't ever know what the other person's really like—I have to find out, and just because this is an African American patient or student doesn't mean that they're exactly like the list says they are."

The politically important categories of race and ethnicity have been fundamental to promoting civil rights, to assessing inequalities and disparities in health, education, housing, civil rights protection, and identifying underrepresented minorities and yet, they now seem—at least in popular culture—to be social labels and analytic categories of another era, with possibly diminished political potency and meaning (Centers for Disease Control and Prevention, 2011; "Race Remixed," 2011).[9] *Shattering culture* also names efforts of clinicians and support staff who attend to emergent and contextually dependent patterns of social categorization and the ways that individuals appropriate and employ cultural difference. For example, language, income, and insurance status were often considered important cultural categories that rivaled or exceeded the importance of race and ethnicity. In using the term "shattering culture," though, we do not intend to discard culture

as a concept with which to think and make sense of the world of medicine and of social life, but rather to note that the *certainty* about the value of older cultural categories of race and ethnicity, used often in establishing social policies for equality and the common good, is shattered.

Why *culture* in addition to cultural competence and evidence-based practice? Culture has long been a fundamental analytic category with political and policy cache in psychiatry and mental health services. We ask, how do mental illnesses vary across cultures? In psychiatric services, how should diagnosis, therapeutics, and the organization of care be tailored to the needs of distinctive cultures and subcultures—or should they? These have been central concerns for nearly the whole of modern psychiatry (Anderson, Jenson, & Keller, 2011; Kleinman & Good, 1986).

Historically rooted in engagements with cultures around the globe since colonial eras (Pols, 2011), psychiatry has held a fascination for cultural difference in how mental illness is expressed, experienced, understood, and treated (B. J. Good & Good, 2010). Thus, psychiatry is the ideal medical specialty to study where "culture counts," what culture means, and how disparities and inequalities in treatment by race and ethnicity are linked to issues of "culture" as they are debated and discussed. It is the field of medicine where the meaning of culture is most seriously and frequently considered and assessed; where culture is used as a clinical frame and a valuable concept for teaching residents how to create trusting relationships with patients (Kleinman & Benson, 2006; Kleinman, Eisenberg, & Good, 1978; Willen, Bullon, & Good, 2010), where universalism and cultural specificity are common in discourses on patient care, therapeutics, and diagnostics; and where cultural systems of meaning and experience are relevant for clinicians as much as for their patients (B. J. Good & Good, 1980). Psychiatry is the medical discipline most often charged with teaching "cultural competence" and cultural sensitivity to medical students, residents, and other clinical trainees, and the specialty most concerned with language barriers and clinician–patient matching (Willen, 2011). In addition, psychiatrists (and sometimes affiliated anthropologists) are most frequently turned to by physicians from other specialties for cultural consultations.[10]

Psychiatry is also the medical specialty that reflects most deeply on its own internal variety and diversity of professional cultures, such as acknowledging the tension between universalism and cultural specificity, as well as the competition among psychodynamic, cultural, biological, and neuroscience and most recently genetic approaches to making sense of mental illness, designing therapeutics, and understanding humankind (Jenkins, 2010; R. Lewis-Fernández, 2011, personal communication; Luhrmann, 2000). For example, today's leading cultural psychiatrists are engaged in shaping cultural ideologies for ethnic specific clinics, creating cultures of clinical practice oriented toward culturally diverse patient populations served, and actively undertaking cross-cultural research.[11] They are currently creating one dimension of psychiatry's culture of the 21st century by developing new diagnostic definitions and illustrative cases where patient culture matters in treatment, for the American Psychiatric Association's *Diagnostic and Statistical*

Manual 5.0, despite the difficulties of convincing the universalists (perhaps the EBP advocates?) the importance and significance of their work.[12] They also debate the merits of universalism and cultural specificity in patient care, exploring ways to balance these two impulses in American psychiatry, "that allow one to transcend difference and seek affinities across cultural boundaries."[13] Thus, it is not surprising that at the heart of today's cultural psychiatry there is a drive toward encompassing cultural particularism into universalism, which is a culturally constructed notion as well. As Roberto Lewis-Fernández, a leading cultural psychiatrist speaking about the work of the DSM-5 working group on culture states, "I am not anti-universalism, but for a more informed universalism."[14]

Similar to many other fields in medicine, psychiatry is also under stress from current financial constraints and chaotic coverage and payment plans, as well as from an explosion in documentation practices and technological modes of regulation and oversight (Bullon, Good, & Carpenter-Song, 2011; Hannah, Park, & Good, 2011). In our research, we asked does economy trump culture? Do financial constraints and documentation practices trump culture? Or is the culture of financing health care and documentation overwhelming cultural considerations in caring for patients?[15] As part of the ethnographic study, patients were also interviewed. Connections to clinicians of ethnicity different from one's own were expressed by patients: "he knows me, I know him," "we speak breast to breast, chest to chest," "it's not like I can't understand what he is saying not like I can't understand his accent, nor he not understand me, it's not like that." Carpenter-Song (2011) and Calabrese (2011) found that clinician recognition was a very important part of the therapeutic experience for patients interviewed in our project.

Culture counts and *unequal treatment:* Questions about evidence, universality, and the politics of science

While psychiatry has long been concerned with cultural differences in access and use of mental health services and in treatment outcomes, quality research began to document significant differences in access to care, treatment quality, and outcomes for racial and ethnic minorities in the United States, leading to debates among psychiatrists, policy makers, and other activists about the potential explanations for these troubling differences (Dohrenwend & Dohrenwend, 1969; Sue, 1977). Some took the particularistic position that "culture counts," arguing that there were cultural barriers to treatment that caused unequal outcomes. They viewed the experience and expression of mental illness as fundamentally different across diverse racial and ethnic groups with different cultural traditions or differential exposure to social experiences such as colonial domination or racism (Gone, 2015, the introduction to this issue; Manson, 2003) and argued differences must be taken into account in order to provide effective and equitable treatment for all (Chang, 2003; Sue, 1998; Surgeon General, 2001). Culturally specific presentations of mental health were seen as emanating from both historical tradition and contemporary experiences of discrimination.

Researchers also proposed that inferior care could be caused by racism or bias on the part of individual providers or the system itself (Smedley, Stith, & Nelson, 2002–2003). Others looked to more universalistic explanations, that racial and ethnic differences in access to psychiatric care, quality of care, and treatment outcomes are due to "universal aspects of mental illness," and that individual characteristics such as social class, poverty, and lifestyle choices are disproportionately present in different groups. Doris Chang, Mary-Jo Good, and Byron Good (2003) edited a collection on the politics and science of mental health for *Culture, Medicine, and Psychiatry* focusing on *Culture, Race, and Ethnicity*, the Surgeon General's (2001) supplement to the original report on mental health (Surgeon General, 1999). In her contribution, Chang (2003) explored the conflicts over what constituted legitimate data on which to base policy, in particular, what was evidence? She found that quantitative data often trumped anthropological and historical data. The contemporary debate over the relationship between evidence-based practice and cultural competence reflect one dimension of this conflict.

Concerns with differences in mental health care by race and ethnicity in the 1960s and 1970s were motivated in part by the identity politics of the time as well as the social movements promoting equality for racial and ethnic groups in the United States. They were also motivated by a global movement of deinstitutionalization to close the mental hospitals and asylums and replace them with community mental health and outpatient services. These two movements transformed American psychiatric treatment from long-term hospitalization or asylum care to short-term stays, outpatient medication, and new experiments in culturally sensitive and tailored treatment at many community mental health centers.[16] Thus, the politics of designing culturally appropriate care radically changed concomitantly with changes in treatment modalities and settings, and "culture, race, and ethnicity" became politically significant to building services designed to serve minority populations.[17]

Themes from this earlier era continue to be central in current discourses about how "culture counts" and how to reduce disparities and "unequal treatment," reflecting a renewed concern in the burden of mental illness for racial and ethnic minorities. Many of the same academics who were advocates for minority mental health in the 1960s and 1970s participated in the production of these 21st century reports and remain leading advocates today. In 1999, the Surgeon General released *Mental Health: A Report of the Surgeon General* that identified the disease burden of mental illness and access to mental health care as an area of growing concern for the United States, but framed the issue in universal terms. The administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), Nelba Chavez noted the contributions "shaped up with insight and eloquence"; yet "the absence of thoroughness in the examination of culture as a component of mental health" left her concerned (Chavez, 2003, p. 391). Academic experts in minority mental health, often members of the groups they study, regarded the exclusion of analyses by culture, race, and ethnicity as deplorable, as did the federal employees most engaged in policies promoting mental health care for ethnic and racial

minorities (see Chang et al., 2003). Chavez and the Deputy Secretary of Health and Human Services (HHS) reached a compromise and agreed "that a focused supplement would be written to the report" (Chavez, 2003, p. 392). Thus they produced *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General* (Surgeon General, 2001) which highlighted the importance of race and ethnicity, declaring "culture counts." They documented ways culture counts in mental health care and health policy through empirical studies identifying by culture, race, and ethnicity, the unequal burden of mental illness, unequal use and access to treatment, and disparities and inequalities in diagnosis, medication, therapeutics, and quality of care (Chang, 2003; Chang et al., 2003; Surgeon General, 2001). "Culture counts" fast became a rallying cry for those promoting programs for minority mental health. The phrase resonates well with the long tradition of using culture as a fundamental albeit diffuse analytic category in psychiatry, justifying attention to cultural variation in the experience and expression of illness and legitimizing investment in culturally tailored mental health services and culturally competent care.[18]

Nonetheless, a tension between impulses to privilege cultural distinctiveness versus universal commonalities is common as well in research which does attend to minority mental health and analytic categories of race and ethnicity.[19,20] Chang characterizes this divide as research which privileges *universal common risk factors* (such as poverty) to explain group difference in mental illness versus that which privileges group specific cultures, histories, and lived experience—such as racism (or colonialism) to explain group differences in mental illness (Chang, 2003, p. 379).[21] Despite these differences among researchers in minority mental health, "culture counts" continues to expand the relevance and develop new meanings of "culture" in psychiatry. The "Culture Counts" movement was given further public exposure and its policy relevance enhanced by the publication of the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley et al., 2002–2003). The report presented a broad overview of NIH research from the decade of the 1990s which empirically documented differences in treatment by race and ethnicity across a wide spectrum of medical and psychiatric conditions (Ayanian, Cleary, Weissman, & Epstein, 1999; Ayanian, Udvarhelyi, Gatsonis, Pasho, & Epstein, 1993; Bach, Cramer, Warren, & Begg, 1999; M.-J. D. Good, James, Good, & Becker, 2003; Smedley et al., 2002–2003; Waters, 2008).[22]

Building on recent NIH research and motivated by its congressional charge, notably led by the Black Congressional Caucus, *Unequal Treatment* continued the critique of solely universalistic explanations for racial and ethnic differences in mental health care, providing evidence for a series of provocative and revolutionary arguments. *Unequal Treatment* demonstrated that differences in care for racial and ethnic minorities exist, even after taking into account universal, individual factors such as insurance status, access to care, and lifestyle choices. The authors referred to these remaining differences as "disparities" in care, which they tied to other more pernicious factors such as clinician bias or racism. This

dramatically shifted the terms of the debate away from the cultural characteristics of racial and ethnic minority members themselves to the culture and institutions of medicine itself—its individual clinicians and health care providers, on medical education, training, research, and institutions of patient care—as a source of disparities in care.[23]

Drawing from theories in social psychology on bias and stereotyping (Dovidio & Gaertner, 2004; Dovidio et al., 2008; van Ryn, 2002), *Unequal Treatment* emphasized personal bias and stereotyping within medicine as explanatory of disparities; yet, it also implicated the broader culture of medicine and the medical gaze (M.-J. D. Good, 1995; M.-J. D. Good et al., 2003). *Unequal Treatment* recommended policies and interventions to redress clinician bias from whatever source it might arise, to reduce disparities and inequalities in care by race and ethnicity. This shift in emphasis (and perhaps blame) from patient culture, race, and ethnicity to the culture of medicine found its way into 21st century NIH research agendas as well as into policies of health care institutions and clinics. Centers for disparities research were soon established in many academic medical centers and teaching hospitals throughout the country, thereby following earlier developments of cultural competence and diversity training that grew in response to the increasing cultural diversity of patient populations (Betancourt, 2003, 2006; Lakes, Lopez, & Garro, 2006; Lo & Stacey, 2008; Lopez, 1997). According to the most recent *National Healthcare Disparities Report* (Department of Health and Human Services, 2011), published by the Department of Health and Human Services, these efforts have successfully expanded access to care and improved the quality of care for racial and ethnic minorities. However, they have not successfully eliminated disparities in care, as racial and ethnic minorities still lag behind Whites in many measures of quality.

The cultural categories salient in these two national discussions—culture, race, and ethnicity for mental health; and race, ethnicity, and at times social class and gender, for disparities, have profoundly influenced the actions of health care institutions and their clinicians and staff, shaping practices designed to respond to the increasingly cultural hyperdiversity of patient populations and to reduce healthcare and health disparities among disadvantaged ethnic and racial minorities. "Culture counts" and "unequal treatment" became the dominant policy themes defining at least in part the role culture plays in all its many meanings in medicine and psychiatry today.

However, the analytic categories of race and ethnicity underlying these dominant policy themes are being challenged by recent demographic trends. Clinics once designed to serve primarily one ethnic community or a few neighborhood ethnic groups are now faced with a complex array of individuals from different and multiple ethnic backgrounds, speaking different languages, with nuanced cultural perspectives, from different social classes, and with complicated historical experiences as well as racial and ethnic identities. These changes call for an expanded investigation of how "culture counts" in American mental health care. Culture may count in contemporary medicine and psychiatry, but in ways that are not well captured by

the analytic research and policy categories that have relied solely on the mandated pentad of the national census. There are vast cultural differences among members of each of the major census categories and each medical institution and profession has its own unique cultural character and institutional history that powerfully shapes care in ways unrelated to simple definitions of race and ethnicity.

Reflections on the culture concept and evidence-based practice

Curiously, the concept of culture as an analytic concept has increasingly been questioned by some anthropologists just as health care institutions and clinicians have routinized concepts and uses of culture as means for improving quality of care and reducing disparities, and as health services researchers have employed "culture" as an independent variable to explain differences in health status and disparities in medical treatment. Anthropologists have grown concerned about the risks of essentializing societies (either as "cultures" plural, or "subcultures" within societies). A good deal of anthropological scholarship in recent years emphasizes how cultural communities and forms of cultural identity are variable, situational, dynamic, and embedded in struggles for power and control over resources.

Our discussions of culture—both patients' cultures and the "culture of medicine" reflect the debates in anthropology of over a quarter century (Goodale, 2009; Marcus & Fischer, 1999). Rather than throwing out the culture concept or judging it as outdated and of scant value, we would caution against essentializing patient or ethnic group "culture," while acknowledging that culture as well as ethnicity and race, continue to hold pragmatic significance for many people, and as such, require continued attention. Clinicians, health policy makers, mental health service providers, and social scientists should be sensitive to the risk of improper stereotypes, but should also be sensitive to the continuing significance of group-based discrimination and the myriad ways culture does shape clinical presentation, doctor–patient interactions, illness experience, and the communication of symptoms.

Determining when it is appropriate to make group-based cultural assumptions in the process of treating an individual patient is one of the key challenges facing medicine today. This process of "dynamic sizing," as the psychologist Stanley Sue (1998) refers to it, is inherently variable and difficult to standardize across clinicians and across treatment protocols. This poses significant challenges to those who wish to standardize high-quality treatment modalities generally, but especially for those who wish to standardize high-quality treatment modalities that take notions of culture into account. Decisions about how much weight to place on cultural factors must be made on a case-by-case basis, and developing guidelines ahead of time to help clinicians navigate the process is likely to prove inadequate without access to the particularities of any given case.

This is particularly evident in the field of refugee health care, where elaborate training manuals and culturally specific treatment programs have been developed for particular cultural groups. Seth Hannah examined a program for Somali

"Bantu" refugees in a community health center near Boston. The program, which was designed to accommodate cultural distinctiveness, was challenged as providers became aware of significant cultural variation and subethnic conflict within the group, and significant individual idiosyncrasy among its members (Hannah, 2011a, 2014). One Somali patient who was identified by the practice as Bantu, herself rejected that label and preferred to identify with a higher status group known as the Madibaan as a way to distinguish herself from her husband and gain power within their relationship. She also had difficulty fitting in with the larger community of Bantu refugees in the clinic who she viewed as beneath her own social status. What is more, the Somali staff hired to provide services to Bantu refugees were a mix of both Bantu and non-Bantu identities, and often argued over who was assigned to treat patients who were not part of their own ethnic group. In this clinic, rich data about the group-based cultural characteristics of Bantus were communicated to medical personnel ahead of time, yet this information was often not relevant or even had negative effects on the daily work of the clinic. In this case, standardized cultural information did not seem to significantly improve the quality of care.

Dennis Wendt and Joseph Gone (2012) point to a similar problem in the standardization of cultural competence, highlighting the tension between what they refer to as "process-oriented" approaches that promote general clinical competence and specific cultural competencies that can identify salient cultural strategies and tactics. Process-oriented approaches focus on "general processes of effective psychotherapy as incidentally applied to this or that ethnoracially diverse client (Wendt & Gone, 2012, p. 209)." This means that by simply being a highly competent therapist or medical practitioner who is appropriately attuned to the lifeworld of the patient, it is possible to discover the meaningful cultural dimensions that may be impacting any particular case. Wendt and Gone argue that this approach, which effectively counters the tendency to overessentialize and improperly apply group-based cultural characteristics to individual patients who depart from group norms, "may come at the cost of the ability to identify any culturally distinctive tactics or strategies at all" (2012, p. 210).

Wendt and Gone's (2012) strategy to combat this polarity is to question the cultural neutrality of the process-oriented approach and to explore innovative, locally controlled treatment programs in indigenous community settings as an alternative way of examining the cultural problematic present in medical encounters. By focusing on real-world cases of treatment modalities and interventions, they found that many putatively emic treatment modalities actually are a hybrid combination of general psychotherapeutic practice and locally determined, culturally tailored treatment. This approach focuses less on how culturally competent a given therapist is and more on "psychotherapeutic interventions as culturally constituted artifacts" (2012, p. 218). This implies that we should shift our energy away from developing training initiatives designed to improve the competence or cultural competence of individual clinicians or extant clinical practices, and toward the development of robust clinical services that appropriately match the mix of

culturally specific and universal treatment needs of particular communities or social groups.

This approach may work especially well in social environments with easily identifiable, culturally bounded groups. Some settings, such as the native communities studied by Wendt and Gone, are characterized by a dominant–subordinate relationship with the "mainstream" population and by a distinct cultural tradition. Here, the development of tailored services that accurately reflect the mix of culturally distinct and universal qualities of the population is feasible, particularly if programs are developed organically over time with a relatively stable patient population. Many examples of this approach exist, such as the work done by Devon Hinton with the Cambodian refugee population in Massachusetts (Hinton, Field, Nickerson, Bryant, & Simon, 2013). However, as our research has shown, such bounded communities are on the decline, and may not accurately describe the majority of treatment settings in the United States (M.-J. D. Good et al., 2011). In cultural environments of hyperdiversity, a prismatic array of identities and cultures are present that are not easily recognized by staff and that do not clearly align with one another (Hannah, 2011b). How is culture to be employed in these clinical settings and communities?

Similar to Wendt and Gone, and other recent ethnographic work in clinical and pedagogical settings,[24] we approached this question through empirical research in clinics with varying levels of racial, ethnic, and cultural diversity (M.-J. D. Good et al., 2011; Hannah, 2011b). Clinicians and staff worked in settings where racial and ethnic boundaries were more complicated than the census-based pentad of ethno-racial classification (Black, White, Hispanic/Latino, Asian, and Native American) implies. Clear boundaries between groups were difficult to discern, and this ambiguity made it difficult to employ group-based targeting of care. With ethnographic and interview data, we documented five broad challenges; (a) multiplicity, where the number of racial and ethnic groups present are numerous, (b) ambiguity, where the racial and ethnic identity of patients is not easily recognized using physical features alone, (c) simultaneity, where patients occupy multiple racial/ethnic categories at once, (d) fluidity, where the self-asserted racial and ethnic identity of patients is flexible or changes over time, and (e) misapplication, where an individual patient's cultural orientation is idiosyncratic and does not significantly resemble the cultural characteristics associated with their racial/ethnic group. We referred to social settings with these five qualities as "cultural environments of hyperdiversity," and showed that in these "hyperdiverse" clinical settings, clinicians and staff members tended to render cultural difference at the individual level and downplay the significance of racial and ethnic boundaries.

Clinicians in our study largely employed the "process-oriented" approach to cultural competence as efforts to apply a priori cultural knowledge or to systematically adapt universal standards of care to suit particular ethnic populations was simply not feasible. Instead, clinicians stressed that culture was extremely important but that they had to discover, through intense one-on-one work with their patients, what their cultural beliefs and experiences were. Contrary to Wendt

and Gone (2012), who argued that this approach is unlikely to yield useful cultural information, we actually found the opposite. For example, a White female primary care physician we interviewed strongly resisted documents instructing clinicians to use the "ethnic food pyramid" when evaluating the dietary habits of her patients. When asked about cultural treatment guidelines for certain ethnic groups, she discussed dietary patterns as an example of a cultural trait that is often misapplied to individual patient. In her view, having an ethnic food pyramid can stereotype individual patients whose diets differ from the norm of their group and that, ultimately, it is impractical to expect doctors to have cultural formulations available for every conceivable group they are likely to encounter. Instead, she favors a more individual approach that deals with these issues on a case-by-case basis, and seeks to determine "Who is the person and what is their sense of culture, whatever culture they are coming from?" The most relevant thing for her is, "what framework they come from, and what their personal background is—personal, cultural, genetic, etc." She is not concerned "whether they fit into a stereotyped culture that we think we might understand," but rather whether "they might be the exception to it."

Exploring culture on a more individual level often led to surprising discoveries, where unexpected identities or cultural preferences emerged as important factors in treatment—not just on a case-by-case basis, but across numerous individuals in the treatment setting (Hannah, 2011a). Cultural difference was important in these settings, but often not in ways that covaried with racial or ethnic identity. Cultural differences among members of the same group were often seen as more salient than cultural differences between groups. Additionally, we found that distinctions between patients were made on the basis of a series of nonethnic forms of cultural difference. Respondents felt that a "definite transition has taken place, from crude ethnic stereotyping to more behavioral-based stereotyping." What language a patient speaks, their propensity for violent or "rowdy" behavior, whether they come from "the streets," are "druggies," come from a long line of "group homes," or whether they were "psychotic" or "borderline" was used to label patients who were often treated as members of small "microcultures" that were recognizable by other clinicians and staff and formed the basis for differential treatment.

The existence of these microemergent cultural factors did not negate the occasional importance of race and ethnicity, however. Clinicians in our study (both inpatient and outpatient) still recognized that race, especially as experienced by individuals with African ancestry, was bound to impact their clinical work. However, they did not assume that it would be a major factor in their work and instead used their individual judgment with particular patients and their collective experience working in particular clinical settings to inform their views. For many clinicians, it was an empirical question how much race, ethnicity, or group-based culture would figure in a given clinical encounter, just another factor to be weighed against other nonracial, non-group-based, more locally or individually relevant factors.

For example, in one of the hyperdiverse inpatient psychiatric clinics we studied, non-Black mental health associates (MHAs) strategically matched Black patients they perceived as "racially defensive" with Black MHAs when the potential for conflict existed. They felt that having an MHA who was an immigrant from Africa but "looked" like the African American patient would help reduce any anxiety the patient might have about being restrained by a predominantly White, potentially racist psychiatric institution. For this purpose, mere physical resemblance was enough to assuage their fears, even though the African MHA and African American patient shared little in the way of cultural similarities. In fact, it was well known on the unit that African MHAs held more negative stereotypes about African American patients than White staff in the clinic.

Moreover, we found that clinical staff in our study were able, using a more universal, individualistic, process-oriented approach to culture to not only discover culturally relevant features unique to their patient population, they were able to recognize when group-based macro processes such as racial perception were also salient—and adjust their behavior accordingly. This result required neither a sustained training program to build cultural knowledge about patient population nor the development of emic, culturally based treatment logics tailored to specific patient populations. In fact, neither of these approaches would have been feasible in a patient population as mixed and unstable as those we encountered in various clinical settings throughout Boston. All that was needed was a body of clinicians and support staff with the awareness that culture is an important factor to be built into how they conduct their work, but that culture is manifest at multiple levels of aggregation—in the unique lived experience of individuals, in the historical legacies of particular ethnic and racial groups, and in the emergent cultures that develop within institutional settings.

We recommend that mental health clinicians and other health professionals consider the local context in which cultural differences become salient, with a much greater appreciation for the diversity of lived experience found among individual patients. This approach implies a reduced reliance on broad cultural categories—those associated with major racial, ethnic, and national identities—in evidence-based practice guidelines. Instead, a case-based approach that catalogues a broad spectrum of culturally relevant clinical dilemmas and solutions and focuses on common best practices regardless of cultural particularity, should be more frequently used.

This is especially the case during periods of rapid demographic change, when the precise configurations of racial, ethnic, and cultural boundaries are in flux. In these settings, the use of group-based identities such as race and ethnicity will still be useful for political purposes but may have less utility in clinical practice as the odds of idiosyncratic deviation from the group norm increase substantially. In settings where more stable group boundaries or a history of dominant group oppression against a minority group exists, a cultural commensurability approach like that advocated by Wendt and Gone (2012), or a deeply culturally tailored approach pursued by Hinton et al. (2013), may be appropriate.

The research we have reviewed here suggests that the precise configuration and stability of racial and ethnic boundaries as well as the degree to which cultural coherence among group members exists is an important factor to be considered when employing cultural constructs in the process of clinical care. What is more, the socially constructed nature of these boundaries makes them variable, which makes the standardization of a one-size-all approach to cultural competence all the more problematic. While it may seem that when racial, ethnic, and cultural boundaries are bright, it should be easier to standardize notions of cultural difference into treatment protocols and training regimes, our findings with respect to a very discrete population of Somali refugees suggests that individual idiosyncrasy and intraethnic conflict can thwart efforts to standardize cultural competent care. And when racial, ethnic, and cultural lines are blurry, our findings suggest that high levels of general clinical competence and an awareness and appreciation for the importance and complexity of cultural experience can combine to develop "culturally competent" treatment, but in unique and flexible ways.

Funding

Notes

1. U.S. Census (1970, 1980, 1990, 2000, 2010).
2. These trends actually extend even further to the post Korean War period when Zborowski (1952, 1969) wrote about the experience of pain in U.S. veterans from different ethnic groups.
3. When Mary-Jo Good taught culture and medicine and psychiatry at UC Davis Medical School in the 1970s, communities of ethnicity were very important to identity politics and health care politics.
4. See Amin (2010), Arehart-Treichel (2004), Khan (2001), Kirmayer (2007), Miyares (2004), and Muir and Wetherell (2010).
5. Although past waves of immigration and past eras of intermarriage evince a long history of complex identities in the United States, Hannah (2011a) argues that the recent demographic trends constitute an acceleration of these trends. In addition, the push for multiracial identification in the U.S. Census is further evidence of increasing complexity.
6. The "Race Remixed" series in *The New York Times* (2011) focuses on how the growing population that self-identifies as multiracial is blurring contemporary notions of race and ethnicity in America (see "Black? White? Asian? More Young Americans Choose All of the Above," by Susan Saulny, Jan 29, 2011).
7. David Hollinger (2006) termed the five major U.S. Census race and ethnicity categories "the ethnic pentagon." Following Hollinger, we refer to these five categories as the "pentad." The modern "ethnic pentagon" first appeared in the 1980 U.S. Census, ushered in by the Office of Management and Budget's "Statistical Policy Directive No. 15," which specified that all federal agencies were to collect data under four racial and one ethnic heading. These stood until 1997, when Native Hawaiian/Pacific Islander became a fifth

racial category and people were permitted to choose more than one race (Hattam, 2005). On racial classification in the census, see Prewitt (2005, 2009) and Waters (2008).

8. See Carpenter-Song, Schwallie, and Longhofer (2007) for a review.

9. "In a Multiracial Nation, Many Ways to Tally," by Susan Saulny, New York Times, Feb. 10, 2011. This article is an example of hyperdiversity. Uncertainty about an individual's culture, race, and ethnicity is common among many young Americans who check "all" or other. Ms. M. is part Irish, Peruvian, Chinese, Cherokee, and Shawnee, is categorized differently depending on who is counting. Her father calls her Hispanic, her mother and she prefer to use other, her best friend uses mixed race. In the census she can use four races, with the U.S. Department of Education she would be Hispanic and with the National Center for Health Statistics she would be Asian.

10. In the 1970s, UC Davis had a cultural consultation clinic of which Mary-Jo Good was a part.

11. Personal conversations with members of the DSM-5 working group on culture including psychiatrists Roberto Lewis Fernandez, Devon Hinton, and Anne Becker, March 2009, November 2009, January 2010, and March 2011.

12. *The DSM-III Case Book* (Spitzer, Skodol, Gibbon, & Williams, 1981) included 87 cases which were primarily White professionals, wealthy business people, or members of the middle class (75%) with 15% being prisoners or unemployed or elderly, and 11% defined as working class; one case suggested a Hispanic ethnic identity (B. J. Good, 1993). In the DSM-IV, 20% of male adults were marked by a race or ethnicity, 13% women (Cermele, Daniels, & Anderson, 2001; Spitzer, Gibbon, Skodol, Williams, & First, 1994).

13. Paraphrase of a comment by Michael Jackson on understanding the human condition and learning how to live with others as an anthropologist. William James Hall, Harvard University, April 15, 2011.

14. Personal conversations with Roberto Lewis-Fernández, March 2011.

15. We refer to the growing demands of documentation as "the paper life," although it is rapidly adding a layer of electronic records, particularly in the "check box" mode. For example, one document asks the clinician to assess, "does patient have culture (yes) (no)." (see Bullon et al., 2011).

16. By the mid-20th century, as massive mental hospitals and asylums began to be regarded as inhumane and deinstitutionalization became the norm, the community health movement began to flourish. While many mentally ill patients had legitimate reasons to fear and distrust the asylum psychiatry of the mid-20th century and the stigmata taint of hospitalization, with the establishment of community mental health services and a sea change in medication options, the treatment for mental illness was less onerous.

17. Mary-Jo Good witnessed and participated in this movement in California as a faculty member of the Department of Psychiatry at UC Davis – Sacramento Medical Center, when the politics of community mental health were favorable. The UC Davis – Sacramento County system sought to balance evidence based practice (EBP) and cultural competence/cultural specific care in its clinical care. Proposition 13 and antitax policies at both the state and federal levels defunded this model system.

18. Joseph Gone's October 2011 conference at University of Michigan had "culture counts" as its theme. The conference, titled *Reconciling Cultural Competence & Evidence-Based Practice in Mental Health Services*, featured contributions by leading experts in the field of culture and psychiatry, psychiatrists, anthropologists and health services researchers.

19. Culture and psychiatry go together and the meaning of each has been dynamic and fluid. Culture has been a central concept for generations in psychiatry in general (Freud), and in American psychiatry in particular. The classic literature in anthropology, culture, and psychiatry is far too vast to be fully referenced here. Several notable publications include Mezzich et al. (1996) *Culture and Psychiatric Diagnosis: A DSM-IV Perspective*; anthropologically important studies including Kleinman and Good's (1986) *Culture and Depression*; Kleinman's (1991) *Rethinking Psychiatry*; and Luhrmann's (2000) *Of Two Minds*. Ethnographic classics include Estroff's (1985) *Making It Crazy*; Rhodes's (1991) *Emptying Beds*; and the sociological classic *Asylums* by Goffman (1961). More recent ethnographic work appears in collections such as Jenkins and Barrett's (2004) *Schizophrenia, Culture, and Subjectivity*; Hinton and Good's *Culture and Panic Disorder* (2009); and Jenkins' (2010) *The Pharmaceutical Self*. Despite this interest in culture, psychiatry has also had significant blind spots and disparities and inequalities in treatment by race (especially Black and White) are documented in Institute of Medicine's (IOM) *Unequal Treatment*, in M.-J. D. Good et al. (2003), and in Jonathan Metzl's (2010) book, *The Protest Psychosis: How Schizophrenia Became a Black Disease*.

20. This tension between universalism and cultural particularism is a different form of dualism, yet recalls Luhrmann's cultural analysis of psychiatry's duality between bioscience and biologically grounded psychiatric practice and psychodynamic therapeutics and practice, in her ethnography, *Of Two Minds* (2000).

21. See 2003 special issue of *Culture, Medicine and Psychiatry*, "The Politics of Science: Culture, Race, Ethnicity" and the supplement to the Surgeon General's Report on Mental Health, where authors tell stories of their contributions to the Surgeon General's supplement, Mental Health: Culture, Race and Ethnicity (Chang et al., 2003; Surgeon General, 2001).

22. This genre of highly influential NIH research was nurtured by the successful political movements and ethnic identity healthcare politics of the late 1980s and early 1990s. In particular, the women's health movement and its congressional advocates, Patricia Schroeder and Olympia Snow, successfully called for research on the diseases of women and minorities and explanations for differences by gender, race, and ethnicity in medical treatment for major disorders such as heart disease. In 1990, "the force of law" mandated inclusion of minorities and women in NIH funded research (Kelty et al., 2007, p. 130), bringing a virtual sea change in the research culture of NIH and along with it the findings of disparities in medical treatment.

23. Although the *Unequal Treatment* report placed greater emphasis on the culture of medicine, this was not the first time the issue was raised in a major government report. The supplement to the Surgeon General's report on mental health (2001) also focused on the culture of medicine in addition to patient culture (see Chapter 2).

24. See the special issue of *Culture, Medicine, and Psychiatry* "Cultural Competence in Action: Multidisciplinary Perspectives on Four Case Studies" (Willen & Carpenter-Song, 2013).

References

Amin, A. (2010). The remainders of race. *Theory, Culture & Society*, *27*, 1–23.

Anderson, W., Jenson, D., & Keller, R. C. (Eds.). (2011). *Unconscious dominions: Psychoanalysis, colonial trauma, and global sovereignties*. Durham, NC: Duke University Press.

Arehart-Treichel, J. (2004). Canadian psychiatrists confront cultural-competency challenges. *Psychiatric News*, *39*, 1–19.

Ayanian, J. Z., Cleary, P. D., Weissman, J. S., & Epstein, A. M. (1999). The effect of patients' preferences on racial differences in access to renal transplantation. *New England Journal of Medicine*, *341*, 1661–1669.

Ayanian, J. Z., Udvarhelyi, I. S., Gatsonis, C. A., Pasho, C. L., & Epstein, A. M. (1993). Racial differences in the use of revascularization procedures after coronary angiography. *Journal of the American Medical Association*, *269*, 2642–2646.

Bach, P. B., Cramer, L. D., Warren, J. L., & Begg, C. B. (1999). Racial differences in the treatment of early-stage lung cancer. *New England Journal of Medicine*, *341*, 1198–1205.

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine*, *78*, 560–569.

Betancourt, J. R. (2006). Cultural competence and medical education: Many names, many perspectives, one goal. *Academic Medicine*, *81*, 499–501.

Bullon, A., Good, M.-J. D., & Carpenter-Song, E. (2011). The paper life of minority and low-income patient care. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 200–216). New York, NY: Russell Sage Foundation.

Calabrese, J. (2011). "The culture of medicine" as revealed in patients' perspectives on psychiatric treatment. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 184–199). New York, NY: Russell Sage Foundation.

Carpenter-Song, E. (2011). Recognition in clinical relationships. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 168–183). New York, NY: Russell Sage Foundation.

Carpenter-Song, E., Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services*, *58*, 1362–1365.

Centers for Disease Control and Prevention. (2011). CDC health disparities and inequalities report – United States. *Morbidity and Mortality Weekly Report*, *60*(Suppl. 14).

Cermele, J. A., Daniels, S., & Anderson, K. L. (2001). Defining normal: Constructions of race and gender in the DSM-IV casebook. *Feminism & Psychology*, *11*, 229–247.

Chang, D. F. (2003). An introduction to the politics of science: Culture, race, ethnicity and the supplement to the Surgeon General's report on mental health. *Culture, Medicine and Psychiatry*, *27*, 373–383.

Chang, D. F., Good, M., & Good, B. J. (Eds.). (2003). The politics of science: Culture, race, ethnicity, and the supplement to the Surgeon General's report on mental health [Special issue]. *Culture, Medicine and Psychiatry*, *27*(4).

Chavez, N. (2003). Commentary. *Culture, Medicine and Psychiatry*, *27*, 391–393.

Daniel, G. R., Kina, L., Dariotis, W. M., & Fojas, C. (2014). Emerging paradigms in critical mixed race studies. *Journal of Critical Mixed Race Studies*, *1*, 6–65.

Department of Health and Human Services. (2011). *National healthcare disparities report 2011*. Washington, DC: Agency for Healthcare Research and Quality.

Dohrenwend, B. P., & Dohrenwend, B. S. (1969). *Social status and psychological disorder: A causal inquiry*. New York, NY: Wiley-Interscience.

Dovidio, J. F., & Gaertner, S. L. (2004). Aversive racism. *Advances in Experimental Psychology*, *36*, 1–52.

Dovidio, J. F., Panner, L. A., Albrecht, T. L., Norton, W. E., Gartner, S. L., & Shelton, J. N. (2008). Disparities and distrust. *Social Science & Medicine*, *67*, 478–486.

Epstein, S. (2007). *Inclusion: The politics of difference in medical research*. Chicago, IL: University of Chicago Press.

Estroff, S. E. (1985). *Making it crazy*. Berkeley: University of California Press.

Flores, G., Gee, D., & Kastner, B. (2000). The teaching of cultural issues in U.S. and Canadian medical schools. *Academic Medicine*, *75*, 451–455.

Ford, J. D. (2008). Trauma, posttraumatic stress disorder, and ethnoracial minorities: Toward diversity and cultural competence in principles and practices. *Clinical Psychology: Science and Practice*, *15*, 62–67.

Goffman, E. (1961). *Asylums*. New York, NY: Anchor Books.

Gone, J. (2015). Reconciling evidence-based practice and cultural competence in mental health services: Introduction to a special issue. *Transcultural Psychiatry*, *52*(2), 139–149.

Good, B. J. (1993). Culture, diagnosis, and comorbidity. *Culture, Medicine and Psychiatry*, *66*, 427–446.

Good, B. J., & Good, M.-J. D. (1980). The meaning of symptoms: A cultural hermeneutic model for clinical practice. In L. Eisenberg, & A. Kleinman (Eds.) *The relevance of social science for medicine* (pp. 165–196). Boston, MA: D. Reidel.

Good, B. J., & Good, M.-J. D. (2010). Amok in Java: Madness and violence in Indonesian politics. In B. J. Good, M. M. J. Fischer, S. S. Willen, & M.-J. D. Good (Eds.) *A reader in medical anthropology: Theoretical trajectories, emergent realities* (pp. 473–480). Malden, MA: Wiley-Blackwell.

Good, M.-J. D. (1995). Cultural studies of biomedicine: An agenda for research. *Social Science & Medicine*, *41*(4), 461–473.

Good, M.-J. D., James, C., Good, B. J., & Becker, A. E. (2003). The culture of medicine and racial, ethnic, and class disparities in healthcare. In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.) *Unequal treatment: Confronting racial and ethnic disparities in health care with CD* (pp. 594–625). Washington, DC: National Academy Press.

Good, M.-J. D., Willen, S. S., Hannah, S. D., Vickery, K., & Park, L. T. (2011). *Shattering culture: American medicine responds to cultural diversity*. New York, NY: Russell Sage Foundation.

Goodale, M. (2009). *Surrendering to utopia: An anthropology of human right*. Stanford, CA: Stanford University Press.

Hannah, S. D. (2008, March). Constructing cultural competence: How the conflation of race and culture hampers the development of appropriate and effective interventions. Paper prepared for the Society for Medical Anthropology annual meeting in Memphis, TN.

Hannah, S. D. (2011a). *Clinical care in environments of hyperdiversity: Race, culture, and ethnicity in a post pentad world* (Doctoral dissertation). Harvard University, Cambridge, MA. Proquest Dissertations and Theses – Gradworks, http://gradworks.umi.com/34/62/3462520.html

Hannah, S. D. (2011b). Clinical care in environments of hyperdiversity. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 35–69). New York, NY: Russell Sage Foundation.

Hannah, S. D. (2014). When Somali is not Somali and Bantu is not Bantu: Hyperdiversity and the use of culture in refugee medicine. Unpublished manuscript.

Hannah, S. D., Park, L. T., & Good, M.-J. D. (2011). Physicians' perspectives on financial barriers to equitable care. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 217–234). New York, NY: Russell Sage Foundation.

Hattam, V. (2005). Ethnicity & the boundaries of race: Rereading Directive 15. *Daedalus*, *134*(1), 61–69.

Hinton, D. E., Field, N. P., Nickerson, A., Bryant, R. A., & Simon, N. (2013). Dreams of the dead among Cambodian refugees: Frequency, phenomenology, and relationship to complicated grief and posttraumatic stress disorder. *Death Studies*, *37*, 750–767.

Hinton, D. E., & Good, B. J. (Eds.). (2009). *Culture and panic disorder*. Stanford, CA: Stanford University Press.

Hochschild, J. L., & Powell, B. M. (2008). Racial reorganization and the United States census 1850–1930: Mulattoes, half-breeds, mixed parentage, hindoos, and the Mexican race. *Studies in American Political Development*, *22*, 59–96.

Hochschild, J. L., Weaver, V. M., & Burch, T. R. (2012). *Creating a new racial order: How immigration, multiracialism, genomics, and the young can remake race in America*. Princeton, NJ: Princeton University Press.

Hollinger, D. A. (2006). *Postethnic America: Beyond multiculturalism*. New York, NY: Basic Books.

Jenkins, J. H. (Ed.). (2010). *Pharmaceutical self: The global shaping of experience in an age of psychopharmacology*. Santa Fe, NM: School for Advanced Research Press.

Jenkins, J. H., & Barrett, R. (Eds.). (2004). *Schizophrenia, culture, and subjectivity: The edge of experience*. Cambridge, UK: Cambridge University Press.

Kelty, M., Bates, A., & Pinn, V. W. (2007). National Institutes of Health policy on the inclusion of women and minorities as subjects in clinical research. In J. I. Gallin, & F. P. Ognibene (Eds.) *Principles and practice of clinical research* (pp. 147–160). Waltham, MA: Elsevier/Academic Press.

Khan, A. (2001). Journey to the center of the earth: The Caribbean as master symbol. *Cultural Anthropology*, *16*, 271–302.

Kim, B. S., Yang, P. H., Atkinson, D. R., Wolfe, M. M., & Hong, S. (2001). Cultural value similarities and differences among Asian American ethnic groups. *Cultural Diversity and Ethnic Minority Psychology*, *7*(4), 343–361.

Kirmayer, L. J. (2007). Cultural psychiatry in historical perspective. In D. Bhugra, & K. Bhui (Eds.) *Textbook of cultural psychiatry* (pp. 3–19). Cambridge, UK: Cambridge University Press.

Kleinman, A. (1991). *Rethinking psychiatry*. New York, NY: The Free Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine*, *3*(10), e294..

Kleinman, A., Eisenberg, L., & Good, B. J. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*, 251–258.

Kleinman, A., & Good, B. J. (Eds.). (1986). *Culture and depression*. Berkeley: University of California Press.

Lakes, K., Lopez, S., & Garro, L. C. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory Research, Practice, Training*, *43*, 380–396.

Lee, J., & Bean, F. D. (2010). *The diversity paradox: Immigration and the color line in the 21st century*. New York, NY: Russell Sage Foundation.

Lo, M. M., & Stacey, C. L. (2008). Beyond cultural competency: Bourdieu, patients and clinical encounters. *Sociology of Health & Illness*, *30*, 741–755.

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

Luhrmann, T. M. (2000). *Of two minds*. New York, NY: Alfred Knopf.

Manson, S. M. (2003). Extending the boundaries, bridging the gaps: Crafting mental health: Culture, race, and ethnicity, a supplement to the Surgeon General's report on mental health. *Culture, Medicine and Psychiatry*, *27*, 395–408.

Marcus, G. E., & Fischer, M. M. (1999). *Anthropology as cultural critique: An experimental moment in the human sciences*. Chicago, IL: University of Chicago Press.

Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Boston, MA: Beacon Press.

Mezzich, J., Kleinman, A., Fabrega, H., & Parron, D. (1996). *Culture & psychiatric diagnosis: A DSM-IV perspective*. Washington, DC: American Psychiatric Press.

Miyares, I. M. (2004). From exclusionary convenient to ethnic hyper diversity in Jackson Heights, Queens. *Geographical Review*, *94*, 462–483.

Muir, R., & Wetherell, M. (2010). *Identity, politics and public policy*. London, UK: Institute for Public Policy Research.

Pols, H. (2011). The totem vanishes, the hordes revolt: A psychoanalytic interpretation of the Indonesian struggle for independence. In W. Anderson, D. Jenson, & R. C. Keller (Eds.) *Unconscious dominions: Psychoanalysis, colonial trauma, and global sovereignties* (pp. 141–166). Durham, NC: Duke University Press.

Prewitt, K. (2005). Racial classification in America: Where do we go from here? *Daedalus*, *134*, 5–17.

Prewitt, K. (2009). *Does (should) racial counting have a future in America?* [Lecture, Kennedy School of Government, Harvard University]. Cambridge, MA.

Race remixed [Series]. (2011). *New York Times*. Retrieved from http://topics.nytimes.com/top/news/us/series/race_remixed/

Rhodes, L. A. (1991). *Emptying beds: The work of an emergency psychiatric unit*. Berkeley and Los Angeles, CA: University of California Press.

Saulny, S. (2011). Black? White? Asian? More young Americans choose all of the above. The New York times, p. 1.

Saulny, S. (2011, February 10). In a multiracial nation, many ways to tally. *The New York Times*, http://query.nytimes.com/gst/fullpage.html?res = 9E01E5DA1E3BF933A25751C0A9679D8B63&module = Search&mabReward = relbias%3Ar%2C%7B%222%22%3A%22RI%3A13%22%7D (accessed 13 November 2014).

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2002–2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

Spitzer, R. L., Gibbon, M., Skodol, A. E., Williams, J. B. W., & First, M. B. (Eds.). (1994). *DSM-IV casebook*. Washington, DC: American Psychiatric Association.

Spitzer, R. L., Skodol, A., Gibbon, M., & Williams, J. B. W. (Eds.). (1981). *DSM-III casebook*. Washington, DC: American Psychiatric Association.

Suárez-Orozco, M. M., Suárez-Orozco, C., & Qin-Hilliard, D. (Eds.). (2005). *The new immigration: An interdisciplinary reader*. New York, NY: Routledge.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, *32*, 616–624.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*, 440–448.

Surgeon General. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.

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

U.S. Census Bureau. (1970, 1980, 1990, 2000, 2010). *U.S. census of population and housing*. Washington, DC: U.S. Census Bureau.

Van Ryn, M. (2002). Research on the provider contribution to race/ethnicity disparities in medical care. *Medical Care*, *40*, I140–151.

Vega, W. A. (2005). Higher stakes ahead for cultural competence. *General Hospital Psychiatry*, *27*, 446–450.

Waters, M. C. (2008). Counting and classifying by race: The American debate. *The Tocqueville Review*, *29*, 1–21.

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry*, *49*, 206–222.

Willen, S. S. (2011). Clinician–patient matching. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 112–130). New York, NY: Russell Sage Foundation.

Willen, S. S., Bullon, A., & Good, M.-J. D. (2010). Opening up a huge can of worms: Reflections on a "cultural sensitivity" course for psychiatry residents. *Harvard Review of Psychiatry*, *18*, 247–253.

Willen, S. S., & Carpenter-Song, E. (Eds.). (2013). Cultural competence in action: Multidisciplinary perspectives on four case studies. *Culture, Medicine, and Psychiatry*, *37*(2).

Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues*, *8*, 16–31.

Zborowski, M. (1969). *People in pain*. San Francisco, CA: Jossey-Bass.

Mary-Jo DelVecchio Good is Professor of Global Health and Social Medicine at Harvard Medical School and affiliated faculty in the Department of Sociology at Harvard University. She codirects, with Byron Good, a Fogarty International Fellows Program for Chinese Psychiatrists at Beijing Institute of Mental Health, Peking University and the Shanghai Mental Health Center. She also directs with Byron Good a USAID funded Inter-University Partnerships for Strengthening Health Systems in Indonesia: Building New Capacity for Mental Health Care, collaborating with the University of Gadjah Mada in Java and Syiah Kuala University in Aceh. Professor Good researches American medicine and psychiatry, most recently exploring unequal treatment and the culture of medicine. She has also carried out research in Indonesia since 1996 on medicine and psychiatry's modernist projects. Since 2005, she has researched high conflict affected regions of Aceh, Indonesia. Recent books include: *Postcolonial Disorders* (2008); *A Reader*

in Medical Anthropology: Theoretical Trajectories, Emergent Realities (2010); and
Shattering Culture: American Medicine Responds to Cultural Diversity (2011).

Seth Donal Hannah is a Postdoctoral Associate at Massachusetts Institute of
Technology. Dr. Hannah researches the intersection of racial inequality and
public policy, with a particular focus on racial and ethnic disparities in health
and health care. His published work examines race, ethnicity, and culture in psy-
chiatric hospitals; medical education; and cultural competence. He coedited the
volume *Shattering Culture: American Medicine Responds to Cultural Diversity*
(2011) and is currently principal investigator of a comparative study of medical
interpreting in three health centers.