Am J Community Psychol (2018) 61:62–75
DOI 10.1002/ajcp.12212

ORIGINAL ARTICLE

A Return to "The Clinic" for Community Psychology: Lessons from a Clinical Ethnography in Urban American Indian Behavioral Health

William E. Hartmann,[1] Denise M. St. Arnault,[2] and Joseph P. Gone[3]

Highlights

- Community psychology (CP) must reengage the clinic setting to address problems in mental health.
- Clinical ethnography represents one promising approach to clinic-based critical CP research.
- Clinicians versed in ecological thinking and contextualist discourses make ideal collaborators.
- Intense contextualism and mutual interests can guide a collaborative CP critique of the clinic.
- Relationally-driven and contextually specific approaches to collaboration are helpful in this work.

© Society for Community Research and Action 2017

Abstract Community psychology (CP) abandoned the clinic and disengaged from movements for community mental health (CMH) to escape clinical convention and pursue growing aspirations as an independent field of context-oriented, community-engaged, and values-driven research and action. In doing so, however, CP positioned itself on the sidelines of influential contemporary movements that promote potentially harmful, reductionist biomedical narratives in mental health. We advocate for a return to the clinic—the seat of institutional power in mental health—using critical clinic-based inquiry to open sites for clinical-community dialogue that can instigate transformative change locally and nationally. To inform such works within the collaborative and emancipatory traditions of CP, we detail a recently completed clinical ethnography and offer "lessons learned" regarding challenges likely to re-emerge in similar efforts. Conducted with an urban American Indian community behavioral health clinic, this ethnography examined how culture and culture concepts (e.g., cultural competence) shaped clinical practice with socio-political implications for American Indian peoples and the pursuit of transformative change in CMH. Lessons learned identify exceptional clinicians versed in ecological thinking and contextualist discourses of human suffering as ideal partners for this work; encourage intense contextualization and constraining critique to areas of mutual interest; and support relational approaches to clinic collaborations.

Keywords American Indians · Clinical ethnography · Community mental health · Culture

✉ William E. Hartmann
weh3@uw.edu

[1] School of Interdisciplinary Arts and Sciences, University of Washington Bothell, Bothell, WA, USA

[2] School of Nursing, University of Michigan, Ann Arbor, MI, USA

[3] Department of Psychology, University of Michigan, Ann Arbor, MI, USA

Introduction

After making significant contributions to burgeoning movements for community mental health (CMH) in the mid-twentieth century, community psychology (CP) began to distance itself from the clinic setting and clinical interventions to imagine new ways of supporting the health and wellness of individuals and communities (Levine & Perkins, 1987; Martin, Lounsbury & Davidson, 2004; Speer et al., 1992). As CP increasingly defined itself in contrast with standard clinical knowledge, institutions, and practices, "the clinic" came to be viewed as an inhospitable setting for the field's growing aspirations. Clinic-based research was described as a vestigial bad "habit" that limited inquiry to only "a small subset of the environments that affect participants' mental health and well-being" (Shinn, 1987, p;.555), and escaping its confines became a major emphasis within CP (see Cowen, 2000; Goodstein & Sandler, 1978). The result has been development and refinement of a host of invaluable extra-clinical tools and frameworks. These CP contributions (a)

extended discussions of health to include broader ideas of wellness and social justice (e.g., Cowen, 1991; Prilleltensky, 2001), (b) refocused attention from healing to prevention and empowerment (e.g., Albee, 1984; Rappaport, 1981), (c) highlighted the role of community organizations and social movements in promoting wellness and preventing distress (e.g., Seidman, 1988; Speer & Hughey, 1995), and (d) advanced collaborative models for community research and action (Trickett & Espino, 2004).

Progress made since separating from CMH to develop CP as an independent field of context-oriented, community-engaged, and values-driven research and action has been marked. However, the clinic remains a powerful, foundational institution within fields of mental health that shapes the lives of diverse people made vulnerable by experiences of distress in overt and subtle ways (see Gomory, 1999; Howe, 1994; Kirmayer, 2007; Rhodes & Jason, 1988; Rose, 1996; Timimi, 2010). Clinical interventions, whether administered in the clinic or community, typically make overt behavioral prescriptions (e.g., drink less, verbalize emotions more) and subtly encourage achievement of socially valued forms of citizenship (e.g., self-sufficiency, economic productivity). The clinic is not only the most common setting for delivery of clinical interventions, it also plays a central role in refining knowledge and practice into an official cannon of "best practices" (e.g., SAMHSA, 2008) for export into allied systems of social development and control within education, criminal justice, and urban youth recreation (e.g., Frazier et al., 2015; Tafrate & Mitchell, 2013; Zirpoli & Melloy, 1993). In the absence of sustained critical engagement by CP, the clinic has only grown in influence, threatening to eclipse attention to socio-political dimensions of human hardship by circulating reductionist biomedical narratives that undermine the emancipatory goals of CP (Humphreys & Rappaport, 1993; Nelson, Lord & Ochocka, 2001; Prilleltensky & Nelson, 2002), marginalize extra-clinical agendas for mental health (Gallagher & Ferrante, 1987; Light, 1987), and constrain possibilities for transformative change in CMH (Nelson, Kloos & Ornelas, 2014; Rappaport, 1992).

Despite the clinic's influence over vulnerable individuals and communities, CP has struggled to critically re-engage this setting. The little work done by CPs in clinic settings often stands apart from the bulk of non-clinical CP research and action for its wholesale adoption of biomedical models of human hardship and clinical prescriptions for wellness. These works—often described as "eliminating barriers to access" for clinical treatment or "cultural adaptation" to modify its appearance—often function to extend rather than challenge the reach of biomedicine. This has contributed to a dearth of compelling clinic-based inquiry bridging clinical and community psychology, which has reified the incompatibility of CP with the clinic setting and curtailed the potential influence of CP in domains of mental health. As a result, distressed individuals seeking professional support encounter a near monolithic mental health establishment that is often found entirely inadequate for alleviating common forms of distress (Kolovos et al., 2017; Lehman, 2010; Rochefort, 1997; Wolitzky-Taylor, Zimmermann, Arch, De Guzman & Lagomasino, 2015) and tragically unresponsive to important cultural and contextual issues (Quintero, Lilliott & Willging, 2007; Shaw, 2012; Whitley, Kirmayer & Groleau, 2006). Failure to re-engage the clinic, then, has positioned CP on the sidelines as fields of mental health gain in influence over the lives of Americans, and increasingly people around the world (see Patel et al., 2011; World Health Organization, 2008), constraining therapeutic possibilities beyond a narrow and poorly functioning clinical establishment that de-politicizes how we understand and respond to human hardship (Conrad, 1992; Humphreys & Rappaport, 1993; Jain & Jadhav, 2009). The resultant forms of CMH have fallen far short of many early CPs' aspirations (e.g., Kelly, 1966).

If CP is to leverage its rich tradition of clinical critique to advance human welfare and help realize early aspirations for CMH, it must reposition itself from the periphery to the center of debates in mental health concerning the roles of established clinical knowledge, institutions, and practices in the pursuit of health, wellness, and empowerment. Rather than revert to forms of CP previously embraced in clinic settings, this "return to the clinic" must leverage principles and competencies developed in decades since abandoning the clinic (e.g., social ecological thinking, social justice agendas) to open new sites for critical clinical-community dialogue locally and nationally to instigate transformative change. Trickett (2015) offered a helpful example of this critical engagement at the national level in a recent analysis of "evidence-based practice" in mental health and education by imploring CP scholars to look beyond rhetoric of change to consider underlying consistencies embedded in the clinical model despite efforts at reinvention (e.g., individual-level analyses). However, for maximal relevance and impact, CPs will need to return to its foundational institution—the clinic—as a site for *critical* research and action (ala Prilleltensky & Nelson, 2009). As there were compelling reasons to escape the clinic, there remain serious challenges to re-engaging this setting without compromising core CP values or principles (see Shinn, 1987). Moreover, Raegan Era cuts to state funding for CMH have resulted in near-constant financial crisis for CMH clinics and facilitated wide-spread adoption of business management models (Rappaport, 1992). These contextual shifts present additional, practical challenges for clinics and CPs interested in developing clinic partnerships for this work.

By presenting the clinic-based project below along with several "lessons learned" we hope to provide guidance and an example of one promising form this return to the clinic might take. In doing so, we underscore that, although not an appealing research agenda for many clinics, there are exceptional individuals in these settings that are ecologically aware and perhaps already engaged in re-imagining clinical services and their role in promoting health and wellness. Moreover, by adopting a relational approach to collaboration, CPs can politicize and constructively critique clinical practice by illuminating social values and cultural assumptions undergirding the clinical establishment and any local modifications or alternatives (e.g., clinician efforts to re-structure therapeutic services to better meet local needs). Importantly, this project complements ongoing CP efforts situated outside the clinic setting by working to disaggregate the mental health establishment and include exceptional clinicians and administrators into coalitions for transformative change in CMH. Thus, to inform and encourage additional works of this kind, we offer a brief project overview, followed by narratives of challenge and lessons learned, and conclude by situating this project in relation to other CP efforts to transform CMH.

A Return to the Clinic: One Example

Project Conceptualization

This project, "Ideas of Culture in an Urban American Indian Behavioral Health Clinic," developed as a brief clinical ethnography in partnership with an urban AI-serving behavioral health (BH) clinic, one of the 34 health organizations in the U.S. funded by the Indian Health Service to meet the health needs of urban AIs. Our primary goal was to develop a contextually rich understanding of how ideas of culture—particularly ideas associated with American Indian (AI) communities—operated in the clinic setting to inform local and national dialogues that would improve BH services with respect to issues of culture, human diversity, and the socio-political interests of AI peoples (e.g., sovereignty). Whereas the preponderance of culture research in BH has relied on clinician and client reasoning alone, often taking the meanings people make about culture for culture itself, this project was informed by an understanding of culture as the underlying fabric of social life that imbues human behavior with meaning and shapes it in ways difficult to recognize and articulate (Geertz, 1973; Good, 1994; Jenkins, Jenkins & Barrett, 2004; Ware & Kleinman, 1992). This is a critical distinction between two traditions of learning about culture: the former, Shweder (1984, 1996) characterized as a "psychological analysis" of how people think and talk about culture, and the latter a "cultural analysis" of how talk about culture—like all human behavior—is informed by a shared set of morally valenced, tacit understandings that are enacted or performed in social interactions (Atkinson, 2001; Camino, 1997; Miles & Huberman, 1994).

Ethnography is ideal for capturing and representing these shared understandings (culture) as distinguished from the meanings made of them (culture concepts; Agar, 1986; Shweder, 1996; Wolcott, 1995). Although not entirely unfamiliar to psychology (Suzuki, Ahluwalia, Mattis & Quizon, 2005) or CP, where Case, Todd and Kral (2014) recently argued it deserves greater attention, ethnography has been most fully elaborated in cultural anthropology and typically involves prolonged engagement in a community setting to systematically triangulate participant observation with data from interviews and other materials (Emerson, Fretz & Shaw, 2011; Miles & Huberman, 1994). The desired product of ethnography is a vivid, well-contextualized picture of community life via elucidation of its cultural foundations (Shweder, 1996), which in this case, means elucidating the "culture of the clinic" (Gone, 2007) by shedding light on the powerful relations between tacit cultural assumptions and clinical practice (e.g., tacit ideas about universal forms of human suffering [e.g., depression], culture as superficial group differences [e.g., different ways of talking about same underlying experience of depression], and clinical practice emphasizing strict implementation of empirically supported treatments). In this way, culturally deconstructing the clinic as a product of tacit beliefs and social values rather than scientific consensus opens dialogue to diverse voices from non-clinicians (e.g., service users, community leaders) that should participate in re-imagining the clinic and its role in pursuing wellness.

Summary of Method and Findings

To render such an understanding, the first author undertook 19 weeks of participant observation (~608 hours) with the supervision of the second and third authors, averaging four full workdays of observation per week in all settings within the clinic except client encounters (e.g., clinic meetings, case consultations, lunch breaks). These data were recorded in field notes and triangulated with data from interviews (58 semi-structured, 57 impromptu open-ended) and the collection of clinic materials (89 files containing myriad clinic handouts, webpage printouts, and pictures of clinic space). This BH clinic was situated within an urban AI community health organization and served as a clinical training site for a prominent state university Master's in Social Work (MSW) program. However, to capture the culture of the clinic, data collection

focused on the clinic's five employed clinicians (all clinical social workers) that most powerfully shaped common understandings and practices. Data were also collected from six MSW student trainees, one cultural aide, one community elder, four administrators, and several health organization staff (many also members of local urban AI community) to contextualize clinician data. By triangulating data from participant observation with interviews and clinic materials, we were able to clarify clinicians' reasoning about culture (explicit talk about culture) and interpret it in relation to shared tacit beliefs and values, as well as external systems and structures, that facilitated and constrained possibilities for clinical practice in this and similar CMH settings.

Data analysis proceeded in two steps. First, we conducted a thematic analysis (Braun & Clarke, 2006) of transcripts from a semi-structured interview about culture in the clinic with the five employed clinicians to capture how they thought and talked about culture in relation to their clinical work. Questions began by exploring clinicians' ideas about culture, followed by how those ideas related to understandings of suffering and healing, and finally, how these ideas related to clinical practice (in general and specifically in this clinic). Second, we turned to the larger data corpus to clarify and contextualize clinicians' thinking about culture by drawing out patterns identified in the field notes that shed light on perplexing findings from the interview analysis (e.g., what forms of AI "traditional culture" fit into 60-minute weekly therapy sessions?; see Hartmann, 2016 for more detail and full interview guide). Through this two-step analytic process, clinician talk about culture—framed within a narrative of Indigenous resistance to whitewashed fields of BH—was parsed from the clinic's social fabric of tacit understandings about personhood, health, suffering and healing, which reflected familiar clinical sensibilities and informed familiar clinical practices (e.g., medicine wheel symbol incorporated into treatment planning but used to support standard client introspection). Findings explored this disjunction to better understand clinician efforts to modify BH services for AI clients and impeding CMH systems and structures (e.g., systems requiring extensive paperwork with diagnostic codes, funding structures that impoverish CMH). Although these findings could have generated tension within the research partnership, commitments to collaboration held, and through dialogue with clinicians and administrators, feedback was incorporated, concerns were largely ameliorated, and the project achieved many (although not all) of its initial goals. Many challenges encountered in this work arose from tensions inherent to pursuing a critical CP agenda in the clinic setting and are likely to re-emerge in future projects of this kind. We now turn to elaborating some of those challenges and highlighting lessons learned from our imperfect attempts to navigate them.

Challenges and Lessons Learned

Identifying Research Partners

CP has made strides in promoting health and wellness through partnerships for research and action with community organizations that share commitments to pursuing social justice, resisting oppression, and empowering those marginalized in society. Clinicians, albeit invested in alleviating human suffering, are not typically trained to reconcile socio-political concerns with the intense daily practice demands of a clinic setting. Instead, the clinic is organized to rapidly and reliably diagnose and treat individual distress with targeted biomedical and psychosocial interventions (e.g., Xanax or exposure-based therapies for specific phobias; Cowen, 1967; Rappaport & Chinsky, 1974; Prilleltensky & Nelson, 2002). As a result, clinical training and practice leave little room for attending to contextual issues or broader agendas of CP (Cowen, 2000; Goodstein & Sandler, 1978; Shinn, 1987). This means many clinics will be uninterested in collaborating on projects of this kind. What, then, might distinguish the few from the many and signal a clinic welcoming of the present endeavor? To address this first challenge, we encourage CPs to look for two characteristics: ecological thinking about client wellness beyond clinic walls and engagement with contextualist discourses of human suffering.

Although traditional clinic settings are structured to facilitate individual healing through brief weekly therapeutic encounters, CMH clinics organized to meet the mental health needs of discrete cultural communities may foster greater awareness of economic, social, and structural circumstances shared by clientele (e.g., systems-level cultural competence ala Pumariega, Rogers & Rothe, 2005). This kind of ecological thinking and concern for context is not uncommon in clinical traditions that emphasize themes of social justice and social determinants of health (e.g., clinical social work). However, to make such an awareness relevant within the clinic beyond simply acknowledging and responding to immediate health impacts, clinicians must also be engaged in contextualist discourses that bridge individual experiences of suffering to broader social patterns and arrangements (e.g., discourses of culture, rehabilitation, human rights, equity—racial, gender, ability, etc.). These discourses encourage openness to re-thinking how suffering is conceptualized, what intervention is prescribed, and how therapeutic services are organized (for example, see Sue & Sue, 1990 on demands of cultural competence changing therapists and therapies).

Each contextualist discourse conceptually bridges individual suffering to broader socio-political contexts, and they invite a restructuring of therapeutic systems and structures to better serve clients for whom the status quo is ill-suited. Thus, traditional clinic settings that employ ecologically aware clinicians engaged in contextualist discourses of human suffering are more likely to be interested in partnering with CP researchers to explore and constructively critique aspects of the clinical enterprise through the lens of a familiar contextualist discourse (in this case, culture).

The BH clinic partnered with for this work was one such ideal partner. Situated in a community health organization developed by and for meeting the health needs of AIs in a Midwestern city, this clinic employed five clinicians—three identified as Native—that regularly engaged with contextualist discourses of culture and were well-versed in ecological thinking. These ideas permeated the clinic from general characterizations of its BH services (e.g., brochure announcing "methods begin with. . .cultural traditions") to case conceptualizations that included attention to "identity distress" due to cultural disconnect stemming from colonial violence. Often, as in these examples, culture talk served to make extra-clinical contextual issues relevant within the clinic, and in addition to ideas of "culture as tradition" common to AI communities, all five clinicians were similarly versed in discourses of culture from clinical training at a nearby MSW program (e.g., cultural competence, cultural humility, cultural safety). Moreover, as a clinical training site, clinicians regularly instructed student trainees and consulted with each other on issues of culture in BH service provision. This made for a warm and supportive clinic environment that encouraged mutual learning and support, as well as critical self-reflection on clinical practice, which lent itself well to participant observation in the present endeavor. Thus, clinicians here were not only aware of socio-political issues impacting local urban AIs and concerned for client well-being beyond clinic walls, they also frequently and thoughtfully engaged with contextualist discourses of culture and valued constructively critical feedback.

Of these characteristics, only clinician interest in culture was apparent prior to initiating a conversation that would lead to project development. As a clinically trained CP interested in issues of culture and mental health, the first author attended a clinic staff meeting and began simply: "I have to complete a dissertation to graduate, and I wonder if it could be useful to this clinic?" Subsequent discussion proceeded in a shared language of "culture," which functioned as a discursive bridge between the concrete realities of clinical work and the socio-political interests of AI peoples. This bridge helped make our contextually oriented critical CP project and its potential contributions legible in the clinic. Although clinicians began with clinically familiar ideas for useful research (e.g., evaluating a culturally adapted intake form), talking about complexities of culture in clinical care moved our discussion toward links between what happens in the clinic and salient socio-political realities for many urban AIs (e.g., multi-tribal communities, social invisibility). Clinicians had clearly put much thought into issues of culture and modified their BH services in response, but conceptualizing and articulating exactly what was different and why was described as frustratingly difficult. The project began to take shape around developing a richly contextualized picture of how clinicians thought about culture and how those ideas related to their clinical practice and the socio-political interests of AI peoples. In response, the first author proposed conducting a brief clinical ethnography, which despite being a less-familiar form of inquiry, was met with enthusiasm by these exceptional clinicians and supported by the health organization's administrative team and community advisory board.

Collecting and Analyzing Data

Ethnography is a powerful approach to contextual inquiry compatible with CP values (Case et al., 2014; see also Schensul, Schensul, Singer, Weeks & Brault, 2015), and its application to clinic settings maintains an extended legacy of challenging established clinical knowledge, institutions, and practices (e.g., Goffman, 1961; Kleinman, 1981; Young, 1995). In many ways, clinical ethnography —or ethnography exploring clinically relevant issues and experiences (Calabrese, 2013)—is ideally suited to the present task of returning CP to the clinic. Recent efforts by clinical ethnographers, for example, have coalesced around critiquing the wanton export of clinical knowledge and practice around the globe (see Burgess, 2016; Jain & Jadhav, 2009; Jain & Orr, 2016), an emancipatory agenda that strongly resonates with CP. Using ethnographic data and clinical expertise, these researchers have offered detailed pictures of community life and hardship in diverse settings to highlight how conflicts between local culture and global mental health can result in detrimental consequences for people in these settings (e.g., Jain & Jadhav, 2009; Sood, 2016; Varma, 2016). Moreover, when conducted in collaborative clinic partnerships, ethnography can also generate productive local sites of clinical-community dialogue that parallel national debates around re-envisioning the clinic and its role in supporting health and wellness for individuals and communities. Generating dialogue locally and nationally, however, will require CPs to immerse themselves in clinic settings for a prolonged and intimate process of ethnographic inquiry while developing a constructive critique that avoids

jeopardizing the research partnership but preserves the integrity of findings. To navigate this second challenge, we suggest limiting critiques to areas of mutual commitment at the latter stages of data collection and analysis (tandem processes in ethnography) and intense contextualization where criticism is essential for an honest depiction of clinic operations.

Extended, open, and exploratory investigation is essential to ethnography and the present task of disentangling rationales used to explain human behavior (e.g., culture concepts) from the non-rational, value-laden tacit assumptions that shape it in less apparent ways (i.e., culture). To develop such an analysis of clinic behavior (i.e., cultural analysis), ethnographers must "bracket" (see Atkinson, 2001; Emerson et al., 2011) expectations and CP sensibilities to become attuned to and gradually unearth the implicit ideas and logics structuring community life of the clinic. This exploratory research process prohibits a priori decisions about timeline, measurement, and outcomes (Atkinson, 2001; Miles & Huberman, 1994), and it requires maintenance of an open disposition to avoid overlooking influential features of the clinic and its clinicians. Bracketing, particularly in the early stages of data collection, cannot be compromised without compromising the integrity of this work. However, as the ethnographer begins to identify and test the limits of patterns in their field notes (see Atkinson, 2001; Emerson et al., 2011), it will be important to consider which patterns merit further elaboration in light of the emerging overall picture of clinic operations and the mutual interests that initially informed the research partnership. This process helps focus subsequent data collection and analysis in ways that support rather than complicate the research partnership and helps to ensure findings remain relevant for all involved. Thus, the goal of ethnography is always to render an accurate depiction of community life—in this case, community life of the clinic—by illuminating its cultural foundations; but researchers sharing CP's collaborative ideals would do well to include the interests and commitments of clinic partners in determining which patterns merit further attention and representation in final reports.

The first author developed this project with BH clinicians during a clinic staff meeting and through subsequent communications with the clinic's administrative team. During this meeting, mutual interests and commitments informing the partnership emerged around the well-being of local urban AIs and, more generally, Indigenous peoples. Clinicians were interested in findings that would inform their clinical work and their understandings of how clinical work squared with broader issues of oppression, AI culture, suffering and healing. The first author, as sole ethnographer, expressed interest in understanding the complexities of culture in the clinic setting to better inform fields of mental health, and this clinic in particular, regarding issues of human diversity. To bracket these hopes and expectations during data collection, several standard ethnographic techniques were used (see Atkinson, 2001; Emerson et al., 2011; Miles & Huberman, 1994). Among them, participant observations initially encompassed all settings where two or more clinicians were present (e.g., meetings, lunches, community events) and semi-structured interview guides were drafted to avoid imposing exogenous ideas on clinicians by inviting them to define terms and frame our exploration of their relations to clinical practice. Only after months of data collection, having identified several patterns of interest and begun testing their limits by requesting impromptu interviews and skill demonstrations (e.g., asking clinicians to talk about or demonstrate how they used a clinical tool), did the first author begin discussing potential costs and contributions of pursuing each pattern with the second and third authors. These discussions informed a process that honed data collection in on the richest settings and participants to flesh out key analyses while avoiding potentially critical analyses deemed irrelevant to the mutual interests that informed project development and unimportant for depicting how culture and culture concepts influenced BH services. Additionally, where analyses were critical of the clinic but important for representing its functioning, patterns were pursued with significant effort to collect additional data that would help contextualize those observations.

Although the possibility for conflict and disagreement is inherent to any collaborative critique, this possibility seemed more probable as data accumulated indicating that ideas about culture were not functioning as clinicians had anticipated and articulated in initial interviews. Specifically, rather than engaging clients with traditional AI cultural forms in therapy (e.g., traditional teachings), clinicians were observed enacting tacit assumptions and values around health and healing from modern clinical training that led to treating culture as a facet of identity to be engaged in standard clinical interventions. This finding —that clinicians were primarily engaged in standard, albeit high quality, clinical practice—represented a valuable ethnographic insight into how the culture of the clinic can override clinician reasoning (in this case about culture) and thereby constrain possibilities for escaping the status quo. Recognizing a potential for tension in the research partnership, data collection shifted to intense contextualization. We broadened the scope of data collection to capture important aspects of clinic-community relations over the past decade (e.g., access to AI traditionalists) and local and national shifts in funding for CMH and AI BH (e.g., shifting demands and opportunities). Final analyses and dialogue with clinicians were then able to explore this

unrecognized reversion to the clinically familiar as an all-but-inevitable result of modern clinical training, constraints of a clinic setting, and economic hardship, while also noting important exceptions to this pattern (e.g., brief cultural practices that fit easily into therapy sessions). By tying these processes together with rich illustrations into a well-contextualized picture of the clinic and its operations, clinicians recognized barriers and pathways to realizing their vision for a clinic supporting client wellness by introducing cultural forms inviting of greater participation in the supportive local AI community. Furthermore, clinicians gained insight into which barriers were amenable to change (e.g., disentangling identity from culture), and which were embedded in clinical practice and the clinic structure, therefore requiring new forms of collaboration with non-clinical professionals (e.g., traditional healers, elders), settings (e.g., community spaces), and interventions (e.g., ceremony).

Negotiating Power in Partnership

Given the precarity of rendering a collaborative critique, it is no surprise that many early clinical ethnographies and observational studies were decidedly uncollaborative and involved researchers going undercover at psychiatric facilities as staff (e.g., Goffman, 1961) or patients (e.g., Rosenhan, 1973). CP, by contrast, was founded with strong collaborative ideals (Bennett et al., 1966). These ideals have rejected potentially exploitative research arrangements in favor of collaborative models that recognize the expertise of community members and share power over the research process with community partners (Churchman, Wiesenfeld & Sadan, 2017). However, within CP and allied social sciences there has been notable confusion and disagreement regarding the exact nature, ethics, and practice of "collaboration" (Trickett & Espino, 2004). In the present work, cultural analysis inherently constrains possibilities for power sharing and participation prior to local dialogue of findings by requiring a distinct authority be retained for the ethnographer to unearth non-obvious influences on human behavior (e.g., tacit assumptions). Moreover, as a critical exploration of clinical practice, higher degrees of clinic control over research process and products may invite skepticism and risk censorship. Thus, a third challenge likely to re-emerge in works of this kind centers on developing a collaborative partnership that addresses concerns for preventing exploitation and preserving the integrity of research findings. Where relationships of trust exist, we suggest an approach to collaboration that is relationally driven and contextually specific to the research partnership and those involved.

A tension between desires for prescribed method and contextual specificity has been widely acknowledged by participatory research theorists (Israel, Eng, Schulz & Parker, 2012), however, predominant approaches to collaborative research in psychology and health fields tend to favor method and procedure. Trickett and Espino (2004) used the language of a "new tyranny" (Cooke & Kothari, 2001) to warn against the pursuit of collaboration via strict implementation of external, bureaucratic decision-making procedures, and reiterating critiques by Wallerstein and Duran (2003), implicate the imposition of rigid procedure in a reification of established power inequities. To strike a balance between prescribed method and contextual specificity, many participatory health researchers emphasize ideals rather than procedures (e.g., "key principles" of CBPR [Israel et al., 2012, pp. 8–11]). However, adopting pre-determined values, ideals, or "goal[s] to strive to achieve" (Israel, Schulz, Parker & Becker, 1998) can similarly constrain research possibilities in ways that preclude cultural analysis (e.g., "all partners participate in… all stages of the research process" [Israel et al., 2012, p. 9]). Instead, we looked to collaborative traditions in contextually-oriented social sciences and applied humanities (e.g., Anthropology, American Indian Studies) for more relationally driven and contextually specific approaches better-suited to cultural analysis. Lassiter (2005), for example, outlined six common strategies for collaboration from the anthropological literature (e.g., including participants as editors of written works, use of community forums for feedback) and underscored the importance of adopting strategies "as appropriate to its individualized relationships and particular contexts" (p. 96). In developing clinic partnerships CPs can discuss process and products of cultural analysis and strategies for participation with collaborators to ensure projects reflect their shared interests and relational connections. Resultant collaborative formations can facilitate a flexible responsiveness to accommodate shifting interests and abilities, which is valuable in protracted research, like ethnography, in settings prone to high turnover or rapid change, like CMH clinics.

Adopting a relational approach to collaboration, we built this project on a foundation of trust developed through a mutually valued, four-year research relationship between the first author and the urban AI health organization. This foundation was further strengthened by the third author's 12-year research relationship with the same organization. Through earlier collaborations, mutual commitments to maintaining good relations had been established and distinctive areas of expertise and authority came to be recognized. Administrators set the agenda and helped develop and approved research proposals, researchers conducted the agreed upon research, and tangible products were co-owned (e.g., an intervention program manual). Thus, beyond a baseline agreement that administrators

and participants would have time to review and comment on presentations and manuscripts prior to publication (this one included), collaborative strategies were allowed to emerge organically through an open-ended invitation for input and negotiation. As a result, the project was able to flexibly respond to the shifting needs of those involved. Clinicians, who were primarily interested in participating near the beginning and end of this project (e.g., setting research goals, approving quotes, discussing findings), responded willingly to a mid-project request by the first author for feedback and input on emerging themes of interest. This input helped to better align the project's emerging direction with clinicians' interests and served as additional data to support or amend patterns identified in the data. Similarly, after an unexpected spike in clinician turnover near project conclusion, the first author revised plans for soliciting feedback to achieve a similar degree of participation from clinicians no longer employed at the clinic. This flexibility afforded by anchoring collaboration in mutual commitments to maintaining good relations rather pre-established protocol allowed for an efficient responsiveness to unforeseen obstacles that may have otherwise derailed our work.

Perhaps the importance of this relational approach was most apparent in our handling of concerns about a written analysis of external funding's role in shaping ideas of culture, clinical practice, and community relations. In this analysis, researchers had identified the influence of external funding—an all-but-necessary resource for navigating the impoverished economic landscape of urban AI BH—in feeding tensions between the health organization and some local AI community members. These intra-community tensions were fed by federal funding agencies that, at critical junctures, pitted local agendas for wellness against national agendas for health (e.g., differing definitions of Indigeneity), creating difficult decisions for the health organization. This story—researchers, clinicians, and administrators agreed—was important to tell as it shed light on a common predicament facing many urban AI health organizations and CMH clinics. However, over the course of this project these tensions had grown and administrators became concerned that a politically charged climate would not be conducive to constructive local dialogue. Rather than defer to external protocol or the interests of a single constituent group (e.g., the researchers or administrators alone), which could have created adversarial relations or led to a breakdown in the partnership, we drew upon our relational commitments to engage in 8 weeks of dialogue and produced a final document that more delicately raised these issues by foregrounding structural tensions. Similar challenges are bound to arise in this return to the clinic, but by anchoring partnerships in relationships of trust, tensions can bring collaborators together with the flexibility to accommodate the varied interest of those involved to the highest degree possible without compromising the integrity of findings. As in this case, the result can be a number of compelling and detailed CP critiques of the clinical establishment that offer valuable insights for local and national dialogues aimed at improving clinical services and challenging broader arrangements of CMH in the U.S. and for AI peoples (see Hartmann, 2016).

Discussion

Community psychology abandoned the clinic and disengaged from movements for CMH to escape clinical convention and develop as an independent field advancing human welfare through community collaborations for socio-political change via contextualist inquiry and community organizing (Martin et al., 2004; Speer et al., 1992). In doing so, CP positioned itself on the sidelines of influential contemporary movements in mental health that, in the absence of more substantive critique and CP insight, have increasingly embraced reductionist biomedical narratives of human hardship that pathologize and de-politicize human suffering (Gomory, 1999; Howe, 1994; Rose, 1996; Timimi, 2010). In response, CP must re-engage the clinic setting—the institutional seat of clinical power—to establish productive new sites for clinic-community dialogue that can instigate transformative change in CMH. Herein, we detailed a recent collaborative clinical ethnography to suggest one possible route back into the clinic that involves partnering with traditional clinic settings to illuminate the tacit, value-laden assumptions undergirding clinical practice and constraining possibilities for alternative therapeutic systems and structures. To that end, we hope CPs will consider developing similar clinic-based critical CP projects that utilize cultural analyses to politicize the status quo and produce vivid, well-contextualized pictures of "the clinic" and its operations to inform local and national dialogues for transformative change. Furthermore, these dialogues around the cultural foundations of CMH can be widely inclusive and accessible, engaging community constituencies around pictures of the clinic that shift dialogue from professional concerns for therapeutic effectiveness to shared beliefs and values around wellness, over which service users and community leaders have significant authority.

Although this work may prove challenging, exceptional clinicians and administrators versed in ecological thinking and contextualist discourses of human suffering (e.g., culture, equity, rehabilitation, human rights) can be found in traditional clinic settings and are more likely to recognize its value and become supportive collaborators. Pairing

critique with collaboration can be challenging, especially in prolonged ethnographic inquiry and for CPs unaccustomed to clinic settings. However, by removing brackets at the latter stages of data collection and analysis, ethnographers can direct critical analyses toward areas of mutual interests and intensely contextualize critical findings to minimize possible tensions in the research partnership. These strategies can help ensure findings remain relevant to clinic partners and informative of widely accessible dialogue at local and national levels. Finally, we argue that a relational approach to collaboration is ideally suited to cultural analysis and addressing concerns for power inequity in the research relationship with avoid both exploitation and censorship. In our work, a track record of commitment to maintaining good relations throughout the research process was an important foundation, and perhaps a prerequisite, for undertaking this relationally flexible collaboration.

Instigating Transformative Change

This return to the clinic complements ongoing movements for transformative change in CMH and identifies an additional role for CPs to play in the process. To support transformative change, critical CPs have taken to promoting the voices of clinical service users (e.g., Copeland, 2010; Janzen et al., 2010), advocating for policy change (e.g., recovery-oriented mental health policy, see Piat & Sabetti, 2009), and developing alternative support systems that would reduce the role of the clinic in society (e.g., Housing First, see Tsemberis, 2010; peer-support, see Davidson et al., 1999). These invaluable efforts situated outside the clinic must continue, yet without direct critical engagement with prominent actors in the influential clinic setting, the clinical establishment can be treated as a monolith and left intact to resist change. Exceptional clinical professionals can be overlooked as potential partners in realizing transformative change, and opportunities to inform dialogue with illustrative clinical ethnographies are lost. This project, then, is about delving back into the clinic for critical inquiry into the CMH establishment and those with power in it (e.g., clinicians, administrators), illuminating otherwise imperceptible cultural dynamics that shape available therapeutic landscapes. Thus, in addition to organizing efforts around alternative therapeutic services and communities, we encourage CPs to develop ethnographic expertise to culturally deconstruct the clinic and inform local and national dialogue. Local dialogue with clinic partners, BH service users, and urban AI community constituencies should culminate in the co-creation of practical steps toward transformative change, while broader dissemination of research findings can advance national dialogues. Moreover, this work can broaden local and national coalitions for transformative change by equipping clinical professionals with the conceptual tools to better articulate limits of clinical intervention and bring them into de-professionalized dialogues with non-clinicians (to develop practical steps toward transformative change, using an empirically grounded depiction of the clinical status quo to inform and structure those efforts.

Although local dialogue was limited following our project's completion, an incidental shortcoming detailed below, post-project feedback with clinicians was promising. Clinicians discussed the importance of further developing the clinic's relationships with AI traditionalists and traditional healers to escape patterns in BH fields of treating culture as a feature of identity to be explored in therapy with standard clinical techniques (e.g., fostering client introspection). Instead, clinicians were interested in facilitating client access to AI healing traditions and community activities outside the clinic setting and in ways that preserved their distinctive cultural meanings. Discussions recognized value in professional delivery of clinical services to address some forms of human hardship, and through engagement with the research findings, came to more clearly articulate the limits of clinical care and a delicate balance in engaging without subsuming local tribes' traditions for promoting individual and community wellness. These comments spoke to interest in medical pluralism, a health service model promoting horizontal power structures that recognize differently credentialed voices, healing traditions, and support services to fit local agendas for health and wellness (Ernst, 2002; Khan, 2006). While not all clinicians were able to discuss findings in-person with the first author, those who did also identified a need for policy change in CMH to allow for greater autonomy to pursue local agendas for wellness informed by respected community members and BH service users. Optimistically, we might imagine continued dialogue would have included these community constituencies, yielded concrete plans for moving toward a system promoting medical pluralism, and perhaps laid the groundwork for a coalition of clinicians, service users, health administrators, community members, and traditional healers advocating for CMH policy change.

Recognizing Human Diversity

Re-imagining more responsive, inclusive, and pluralistic therapeutic systems could significantly improve clinical and support services for individuals with mental health challenges and communities whose experiences of hardship currently go unacknowledged and unaddressed. Pressures from decreased CMH funding and movements for evidence-based practice have led CMH clinics to adopt a limited, homogenous set of clinical services that tend to

favor reliable implementation of empirically supported treatments over contextually relevant strategies for client healing, recovery, and empowerment (Lehman, 2010; see Wexler, 2011). This not only limits opportunities for extra-clinical programing in CMH, but it also works to homogenize human experience in moments of vulnerability and displace competing narratives approaching hardship through lenses of inequity, oppression, and resistance (e.g., AI cultural revitalization). By working collaboratively with clinical professionals attuned to the limits of clinical practice and interested in advancing social justice agendas around human diversity, CPs can use clinical ethnography to recast the clinic, clinical practice, and local alternatives as sites of cultural presence and absence, centering the experiences of service users and fostering critical dialogue around points of conflict and synergy between clinical cannon, experiences of hardship, and agendas for wellness.

These socio-political concerns are particularly salient for culturally marginalized communities, like AIs, for whom problem trends in CMH can incite divisiveness and threaten cultural erasure (see Gone, 2008; Hartmann & Gone, 2016; Wexler, 2011). In this ethnography, cultural complexities were documented that could help inform clinical services more responsive to cultural formations familiar to service users and better aligned prescriptions by AI political theorists that warn against the allure of a "politics of recognition" that treats culture as a modern American identity (see Coulthard, 2007; Simpson & Smith, 2014). Through discussing research findings and concepts of medical pluralism, clinicians explored differences between representing Indigenous identities versus other cultural forms in clinical practice and underscored the importance of enabling client choice between distinctive healing traditions. This, clinicians noted, would require strengthened relationships with respected AI elders and traditionalists, a feasible first step. Unfortunately, further dialogue and planning for transformative change with clinic partners and local urban AI community constituencies was hampered by the near complete turnover of clinicians, heightened local tensions, and the first author's subsequent graduation and relocation out-of-state. Nevertheless, local dialogue may be re-initiated at a later date and lessons learned from this collaborative work will be used to help other AI health organizations and CMH clinics navigate similar dilemmas while advancing national dialogues to inform more culturally responsive and socio-politically empowering therapeutic systems and services reflective of the human diversity of modern America and Indigenous peoples.

Areas for Improvement

Perhaps where this project most notably fell short of its potential was in instigating sustained local dialogue at the partner health organization and in the local urban AI community, both goals of the initial research partnership and vital to elevating client and community voices in guiding subsequent change. Lessons learned will be used to advocate for change to CMH for AIs nationally and local dialogue may be re-initiated at a later date. However, the unexpected turnover of all but one clinician near project conclusion raised difficult questions regarding how to navigate heightened community tension and varied ideas about local dissemination absent the project's strongest and most involved advocates. The unexpectedness of this turnover was largely the result of limited communication between researchers and clinicians during the first author's planned absence from the clinic for a program-mandated clinical internship year. Although our relational approach to collaboration allowed for the continued involvement of clinicians and other participants in refining interpretations of the data, it was unclear how to weigh different ideas about dissemination given its potential impact on the health organization. Absent clinicians, administrators became the primary voices in discussing how to best engage local audiences around findings. Notably, despite the atmosphere of heightened tension, we were encouraged to offer a 50-minute presentation at an open forum. This did due diligence for initial agreements that health organization staff, BH service users, and local urban AIs would be informed of research findings, and it did so without fueling tensions or undermining the research partnership. It did not, however, fulfill some hopes for more sustained dialogue at the community health organization with local urban AIs, BH service users, and newly hired clinicians that could have led to clear, pragmatic steps toward transformative change.

Although this shortcoming could be avoided with extended timelines, more consistent communication, and better luck (i.e., not having near-complete turnover in the final weeks of the project), future CP-clinic partnerships might consider more encompassing clinical ethnographies that include client and community voices prior to dialogue in data collection and project design. The scope of this project was limited by the first author's graduation timeline and available funding, which led to focused attention on clinicians and administrators (i.e., those with power over clinic operations), limited attention to community perspectives from organization staff and an influential community elder to contextualize clinician data, and no attention to experiences of BH service users. Without local dialogue, client voices went unrepresented in our work. While the project of culturally deconstructing the clinic requires focused attention on those with power over its operations (typically, clinicians and administrators), including client and community voices at all stages of the research process could help ensure sustained local

dialogue of findings, enrich it with their valuable perspectives, and support its translation into meaningful change.

Another area for improvement identified by clinicians in feedback following project completion was a lack of policy and practice recommendations offered by the research team in response to critical analyses. Although the charged environment around dissemination may have stifled local dialogue, had the research team better anticipated these circumstances, we could have responded with more directive discussions of challenges highlighted in our findings to inform the co-creation of pragmatic solutions. Initial plans anticipated that responses to issues raised by this project would emerge organically through dialogue, an approach informed by an acute awareness of the first author's position as a non-Native community outsider. This made him reluctant to suggest possible solutions to problems of negotiating Indigeneity in relation to the clinical establishment and settler society. However, absent more substantive local dialogue to generate those solutions, two clinicians fairly noted a reluctance on the part of the first author to weigh in on possible solutions to identified problem areas. Perhaps a compromise that would have avoided imposing exogenous solutions and critiquing without recommending possible changes could have involved highlighting key tensions and walking out possible routes forward in a way that structured dialogue but encouraged creative alternatives. This shortcoming could have been mitigated with more consistent communication during the first author's planned absence from the clinic. Importantly, then, this work feasible for any CP willing to take up clinical ethnography for cultural analysis, and the larger project of returning CP to the clinic could benefit from researchers approaching clinic partnerships with more extended timelines, strong relationships, and diverse positionalities that can contribute to a more robust picture of the clinic deconstructed through multiple lenses. Most notably, women researchers, Indigenous citizenship, local community membership, and histories of psychiatric service use/survival could all inform distinctly illuminating emphases for ethnographic inquiry and potentiate different kinds of dialogue with multiple constituencies around research findings.

Conclusion

In sum, to counter the harmful and growing influence of biomedical reductionism on mental health in the U.S. and in AI communities, CP must re-engage the clinic setting and help transform CMH by illuminating and politicizing cultural assumptions and social values undergirding the clinical establishment. This is a project of cultural deconstruction aimed at informing local and national dialogues that might transform CMH. To illustrate the feasibility of this work for CPs interested in taking up clinical ethnography to render a cultural analysis of clinical practice, we detailed our recent clinic collaboration and offered lessons learned. In relating this story, we suggested looking for exceptional clinicians or administrators versed in ecological thinking and contextualize discourses of human suffering, we encouraged navigating the precarity of collaborative critique by constraining critical analyses to areas of mutual interest and pursuing intense contexualization where such analyses are essential to an honest depiction of the clinic, and lastly, we underscored the value of a relationally driven approach to collaboration. In our experience, these strategies enabled an exciting research collaboration that produced several novel CP critiques of "the clinic" shedding light on multiple pathways and barriers to transformative change in CMH. These insights have informed several conference presentations that are now being prepared for publication to advance national debates around clinical practice and human diversity in CMH. This project can also instigate local dialogue with clinic partners and local community constituencies to co-create concrete steps for transformative change, an outcome that was not realized in our partnership. Importantly, this shortcoming was only incidental and could be mitigated in future endeavors with time and money to support sustained dialogue. Finally, we would like to see more CPs of diverse backgrounds and experiences (e.g., clinical service users) take up this call to re-engage traditional clinic settings to collectively represent a more robust picture of the clinic deconstructed and push debate around the cultural foundations of clinical practice toward the center of efforts to re-imagine and transform CMH.

Acknowledgments This research was financially supported by the Horace H. Rackham School of Graduate Studies at the University of Michigan. The work described in this manuscript complies with ethical standards.

Conflict of Interest

We have no conflicts of interest to disclose.

References

Agar, M. (1986). *Speaking of ethnography*. London: SAGE.

Albee, G. (1984). Prologue: A model for classifying prevention programs. In J. Joffe, G. Albee & L. Kelly (Eds.), *Readings in primary prevention of psychopathology: Basic concepts* (pp. ix–xviii). Hanover, NH: University Press of New England.

Atkinson, P. (Ed.) (2001). *Handbook of ethnography*. Thousand Oaks, CA: SAGE.

Bennett, C., Anderson, L., Cooper, S., Hassol, L., Klein, D., & Rosenblum, G. (1966). *Community psychology: A report of the Boston Conference on the education of psychologist for community mental health*. Boston: Boston University.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Burgess, R. (2016). Policy, power, stigma, and silence: Exploring the complexities of a primary mental health care model in a rural South African setting. *Transcultural Psychiatry*, *53*, 719–742.

Calabrese, J. D. (2013). *A different medicine: Postcolonial healing in the Native American Church*. Oxford, UK: Oxford University Press.

Camino, L. A. (1997). What can anthropologists offer ethnographic program evaluation? *NAPA Bulletin*, *17*, 41–57.

Case, A., Todd, N., & Kral, M. (2014). Ethnography in community psychology: Promises and tensions. *American Journal of Community Psychology*, *54*, 60–71.

Churchman, A., Wiesenfeld, E., & Sadan, E. (2017). On participation and participatory practices. In M. A. Bond, I. G. de Serrano & C. Keyes (Eds.), *APA handbook of community psychology* (pp. 315–334). Washington, DC: American Psychological Association.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, *18*, 209–232.

Cooke, B., & Kothari, U. (2001). *Participation: The new tyranny*. London: Zed Books.

Copeland, M. E. (2010). *Wellness recovery action plan* (2nd edn). Dummerston, VT: Peach Press.

Coulthard, G. S. (2007). Subjects of empire: Indigenous peoples and the 'politics of recognition' in Canada. *Contemporary Political Theory*, *6*, 437–460.

Cowen, E. L. (1967). Emergent approaches to mental health problems: An overview and directions for future work. In E. L. Cowen, E. A. Gardner & M. Zax (Eds.), *Emergent approaches to mental health problems*. New York: Appleton-Century-Crofts.

Cowen, E. L. (1991). In pursuit of wellness. *American Psychologist*, *46*, 404–408.

Cowen, E. L. (2000). Community psychology and routes to psychological wellness. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 79–99). New York: Kluwer Academic Press.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, *6*, 165–187.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

Ernst, W. (2002). *Plural medicine, tradition and modernity, 1800–2000*. New York: Routledge.

Frazier, S., Dinizulu, L., Rusch, S., Boustani, M., Mehta, D., & Reitz, M. (2015). Building resilience after school for early adolescents in urban poverty: Open trial of Leaders @ Play. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*, 723–736.

Gallagher, E., & Ferrante, J. (1987). Medicalization and social justice. *Social Justice Research*, *1*, 377–392.

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

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

Gomory, T. (1999). Programs of Assertive Community Treatment (PACT): A critical review. *Ethical Human Sciences and Services*, *1*, 147–163.

Gone, J. P. (2007). "We never was happy living like a Whiteman": Mental health disparities and the postcolonial predicament in American Indian communities. *American Journal of Community Psychology*, *40*, 290–300.

Gone, J. P. (2008). Introduction: Mental health discourse and western cultural proselytization. *Ethos*, *36*, 310–315.

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

Goodstein, L. D., & Sandler, I. (1978). Using psychology to promote human welfare: A conceptual analysis of the role of community psychology. *American Psychologist*, *33*, 882–892.

Hartmann, W. E. (2016). *Ideas of culture in an urban American Indian behavioral health clinic*. Doctoral dissertation, ProQuest Dissertations Publishing (103916008).

Hartmann, W., & Gone, J. (2016). Psychological-mindedness and American Indian historical trauma: Interviews with service providers from a Great Plains reservation. *American Journal of Community Psychology*, *57*, 229–242.

Howe, D. (1994). Modernity, postmodernity and social work. *British Journal of Social Work*, *24*, 513–532.

Humphreys, K., & Rappaport, J. (1993). From the community mental health movement to the war on drugs. *American Psychologist*, *48*, 892–901.

Israel, B., Eng, E., Schulz, A. J., & Parker, E. A. (2012). *Methods for community-based participatory research for health* (2nd edn). Hoboken, NJ: Wiley.

Israel, B., Schulz, A., Parker, E., & Becker, A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202.

Jain, S., & Jadhav, S. (2009). Pills that swallow policy: Clinical ethnography of a community mental health program in Northern India. *Transcultural Psychiatry*, *46*, 60–85.

Jain, S., & Orr, D. M. R. (2016). Ethnographic perspectives on global mental health. *Transcultural Psychiatry*, *53*, 685–695.

Janzen, R., Ochocka, J., Jacobson, N., Maiter, S., Simich, L., Westhues, A., … & The Taking Culture Seriously Partners (2010). Synthesizing culture and power in community mental health: An emerging framework. *Canadian Journal of Community Mental Health*, *29*, 51–67.

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

Kelly, J. G. (1966). Ecological constraints on mental health services. *American Psychologist*, *21*, 535–539.

Khan, S. (2006). Systems of medicine and nationalist discourse in India: Towards new horizons in medical anthropology and history. *Social Science & Medicine*, *62*, 2786–2797.

Kirmayer, L. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry*, *44*, 232–257.

Kleinman, A. (1981). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkley, CA: UC Press.

Kolovos, S., van Tulder, M. W., Cuijpers, P., Prigent, A., Chevreul, K., Riper, H., & Bosmans, J. E. (2017). The effect of treatment as usual on major depressive disorder: A meta-analysis. *Journal of Affective Disorders*, *210*, 72–81.

Lassiter, L. (2005). Collaborative ethnography and public anthropology. *Current Anthropology*, *46*, 83–106.

Lehman, A. (2010). Adopting evidence-based practices—our hesitation waltz. *Schizophrenia Bulletin*, *36*, 1–2.

Levine, M. & Perkins, D. V. (1987). *Principles of community psychology : Perspectives and applications*. New York, NY: Oxford University Press.

Light, D. W. (1987). Social control and the American health care system. In H. E. Freeman & S. Levine (Eds.), *Handbook of*

medical sociology (pp. 456–548). Washington, DC: American Sociological Association.

Martin, P., Lounsbury, D., & Davidson, W. (2004). AJCP as a vehicle for improving community life: An historic-analytic review of the journal's contents. *American Journal of Community Psychology*, *34*, 163–173.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd edn). Thousand Oaks, CA: Sage Publications.

Nelson, G., Kloos, B., & Ornelas, J. (2014). Transformative change in community mental health: A community psychology framework. In G. Nelson, B. Kloos & J. Ornelas (Eds.), *Community psychology and community mental health* (pp. 3–22). Oxford, UK: Oxford University Press.

Nelson, G., Lord, J., & Ochocka, J. (2001). *Shifting the paradigm in community mental health: Towards empowerment and community*. Toronto, ON: University of Toronto Press.

Patel, V., Collins, P. Y., Copeland, J., Kakuma, R., Katontoka, S., Lamichhane, J., . . . & Skeen, S. (2011). The movement for global mental health. *Transcultural Psychiatry*, *198*, 88–90.

Piat, M., & Sabetti, J. (2009). The development of a recovery-oriented mental health system in Canada: What the experience of commonwealth countries tells us. *Canadian Journal of Community Mental Health*, *28*, 17–33.

Prilleltensky, I. (2001). Value-based praxis in community psychology: Moving toward social justice and social action. *American Journal of Community Psychology*, *29*, 747–778.

Prilleltensky, I., & Nelson, G. B. (2002). *Doing psychology critically: Making a difference in diverse settings*. Gordonsville, VA: Palgrave Macmillan.

Prilleltensky, I., & Nelson, G. B. (2009). Community psychology: Advancing social justice. In D. R. Fox, I. Prilleltensky & S. Austin (Eds.), *Critical psychology: An introduction* (2nd edn, pp. 126–143). Thousand Oaks, CA: Sage.

Pumariega, A., Rogers, J., & Rothe, K. (2005). Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health Journal*, *41*, 539–555.

Quintero, G. A., Lilliott, E., & Willging, C. (2007). Substance abuse treatment provider views of "culture": Implications for behavioral health care in rural settings. *Qualitative Health Research*, *17*, 1256–1267.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, *9*, 1–25.

Rappaport, J. (1992). The death and resurrection of a community mental health movement. In M. Kessler, S. E. Goldston & J. M. Joffe (Eds.), *The present and future of prevention: In honor of George W. Albee: The Vermont Conference Series on the primary prevention of psychopathology* (Vol. 15, pp. 78–98). London: Sage.

Rappaport, J., & Chinsky, J. M. (1974). Models for delivery of service from a historical and conceptual perspective. *Professional Psychology*, *5*, 42–50.

Rhodes, J., & Jason, L. (1988). *Preventing substance abuse among children and adolescents*. New York: Pergamon Press.

Rochefort, D. (1997). *From poorhouses to homelessness: Policy analysis and mental health care*. Westport, CT: Auburn House.

Rose, N. (1996). *Inventing our selves: Psychology, power, and personhood*. Cambridge, UK: Cambridge University Press.

Rosenhan, D. (1973). On being sane in insane places. *Science*, *179*, 250–258.

Schensul, S. L., Schensul, J. J., Singer, M., Weeks, M., & Brault, M. (2015). Participatory methods and community-based collaborations. In H. Bernard (Ed.), *Handbook of methods in cultural anthropology* (2nd edn). Lanham, UK: Rowman & Littlefield.

Seidman, E. (1988). Back to the future, community psychology: Unfolding a theory of social intervention. *American Journal of Community Psychology*, *16*, 3–24.

Shaw, S. (2012). *Governing how we care: Contesting community and defining difference in U.S. public health programs*. Philadelphia: Temple University Press.

Shinn, M. (1987). Expanding community psychology's domain. *American Journal of Community Psychology*, *15*, 555–574.

Shweder, R. A. (1984). Anthropology's romantic rebellion against the enlightenment, or there's more to thinking than reason and evidence. In R.A. Shweder & R.A. LeVine (Eds.), *Culture theory: Essays on mind, self, and emotion* (pp. 27–66). New York, NY: Cambridge University Press.

Shweder, R. A. (1996). True ethnography: The lore, the law, and the lure. In R. Jessor, A. Colby, & R. A. Shweder (Eds.), *Ethnography and human development: Context and meaning in social inquiry* (pp. 15–52). Chicago, IL: The University of Chicago Press.

Simpson, A., & Smith, A. (2014). Introduction. In A. Smith & A. Smith (Eds.), *Theorizing Native studies* (pp. 1–30). Durham, NC: Duke University Press.

Sood, A. (2016). The Global Mental Health movement and its impact on traditional healing in India: A case study of the Balaji temple in Rajasthan. *Transcultural Psychiatry*, *53*, 766–782.

Speer, P., Dey, A., Griggs, P., Gibson, C., Lubin, B., & Hughey, J. (1992). In search of community: An analysis of community psychology research from 1984–1988. *American Journal of Community Psychology*, *20*, 195–209.

Speer, P. W., & Hughey, J. (1995). Community organizing: An ecological route to empowerment and power. *American Journal of Community Psychology*, *23*, 729–748.

Substance Abuse and Mental Health Association (2008). National registry of evidence-based programs and practices. Available from: https://www.samhsa.gov/nrepp [last accessed January 25, 2017].

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. Hoboken, NJ: John Wiley & Sons.

Suzuki, L. A., Ahluwalia, M. K., Mattis, J. S., & Quizon, C. A. (2005). Ethnography in counseling psychology research: Possibilities for application. *Journal of Counseling Psychology*, *52*, 206.

Tafrate, R. C., & Mitchell, D. (2013). *Forensic CBT a handbook for clinical practice*. Hoboken, NJ: Wiley.

Timimi, S. (2010). The McDonaldization of childhood: Children's mental health in neo-liberal market cultures. *Transcultural Psychiatry*, *47*, 686–706.

Trickett, E. J. (2015). Seymour Sarason remembered: "Plus ça change. . .", "psychology misdirected", and "community psychology and the anarchist insight." *American Journal of Community Psychology*, *56*, 197–204.

Trickett, E. J., & Espino, S. L. (2004). Collaboration and social Inquiry: Multiple meanings of a construct and its role in creating useful and valid knowledge. *American Journal of Community Psychology*, *34*, 1–69.

Tsemberis, S. (2010). *Housing First: The Pathways model to end homelessness for people with mental health and substance use disorders*. Center City, MN: Hazelden.

Varma, S. (2016). Disappearing the asylum: Modernizing psychiatry and generating manpower in India. *Transcultural Psychiatry*, *53*, 783–803.

Wallerstein, N., & Duran, B. (2003). The conceptual, historical, and practice roots of community based participatory research and related participatory traditions. In M. Minkler & N. Wallerstein (Eds.), *Community-based participatory research for health* (pp. 27–52). San Francisco: Jossey-Bass.

Ware, N. C., & Kleinman, A. (1992). Culture and somatic experience: The social course of illness in neurasthenia and chronic fatigue syndrome. *Psychosomatic Medicine*, *54*, 546–560.

Wexler, L. (2011). Behavioral health services "don't work for us": Cultural incongruities in human service systems for Alaska Native communities. *American Journal of Community Psychology*, *47*, 157–169.

Whitley, R. J., Kirmayer, L., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal. *Canadian Journal of Psychiatry*, *51*, 205–209.

Wolcott, H. F. (1995). *The art of fieldwork*. Walnut Creek, CA: AltaMira.

Wolitzky-Taylor, K., Zimmermann, M., Arch, J. J., De Guzman, E., & Lagomasino, I. (2015). Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings? *Behaviour Research and Therapy*, *72*, 9–17.

World Health Organization (2008). *mhGAP Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders*. Geneva, Switzerland: Author.

Young, A. (1995). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.

Zirpoli, T., & Melloy, K. J. (1993). *Behavior management: Applications for teachers and parents*. New York: Macmillan.