Evidence-Based Treatment and Cultural Competence in American Indian Behavioral Health
Opening

- Who Am I?
  - Academic Psychologist
    - Clinically-Trained
    - Community-Engaged
    - Culturally-Attuned
  - Research Interests
    - Culture & Mental Health
    - Indigenous Psychologies
    - Cross-Cultural Interventions
Professional Mental Health (MH) Treatments & American Indian (AI) Therapeutic Traditions

- Clear & alarming MH inequities afflict many AI communities → How to remedy?

- Access to professional MH treatments is limited → How to increase availability & use?

- Relevance of professional MH treatments is disputed → What alternatives should be pursued?

- Advocacy for local or traditional therapeutic interventions is rising → How do we know what works?
The Postcolonial Predicament

Round 1
The Postcolonial Predicament

- AI MH Disparities *(Gone & Trimble, 2012)*

  Pronounced MH problems
  +
  Underfunded MH services
  =
  Expand MH services!!! (right?)
The Postcolonial Predicament

- **Traveling Thunder’s Explanatory Model** *(Gone, 2007, 2008b)*

  - First Era: Paradise – Precolonial Existence
    - Perfect harmony & balance owing to strict observation of custom
  
  - Second Era: Conquest – Colonial Contact
    - Annihilation of Indigenous custom
  
  - Third Era: Loss – Postcolonial Effects
    - Anomie leads to pathology
    - The “Whiteman system” as pathogenic
  
  - Fourth Era: Revitalization – Postcolonial Remedy
    - Return to Indigenous (especially sacred) custom
Traveling Thunder’s Explanatory Model (cont)

- Clear Pathological Process
  - Cultural Repression → Anomie → Substance Abuse → Depression → Worthlessness → Suicide

- Little Elaboration of Personal Distress
  - Relatively non-bio/psychological account
  - Emphasized history, culture, & spirituality
Traveling Thunder’s Explanatory Model (cont)

- Pathogenic Aspects of the “Whiteman System”
  - Colonization as cause of Native distress
  - Systemic factors over intrapersonal factors
  - Shared community vulnerabilities
  - Cf. “Historical Trauma” (but without reference to trauma)

- Relevance of Psychosocial Interventions & MH Services?
**Traveling Thunder’s View of Mental Health Services**

“I guess it’s like a war, but they’re not using bullets anymore.... They want to wipe us out.... And therefore the Indian problem will be gone forever.... But they’re using a more shrewder way than the old style of bullets.... If you look at the big picture, you look at your past, your history, where you come from...and you look at your future where the Whiteman’s leading you, I guess you could make a choice. Where do I want to end up? And I guess a lot of people... want to end up looking good to the Whiteman.... Then it’d be a good thing to do: go [to the] white psychiatrists...in the Indian Health Service and say,...’Go ahead and rid me of my history, my past, and brainwash me forever so I can be like a Whiteman.... I guess that’d be a choice each individual will have to make.”

- MH Treatment as Cross-Cultural Encounter

- MH Services as *Implicit Western Cultural Proselytization*
Defining the (Post)colonial Predicament (*Gone*, 2007, 2008a)

- On one hand, *urgent community needs*...
  - Impoverished, high-risk settings
  - Documented disparities in mental health status

- On the other hand, *incongruent clinical services*
  - “Brainwash me forever so I can be like a Whiteman”
  - Attested to by community anecdote & research evidence
Case for AlterNative Therapies

Round 2
Case for AlterNative Therapies

Professional Remedy?

Cultural Competence

- Reaction to “monocultural bias” in the MH professions
- Countering racist invalidations of vulnerable clients
- Tailoring psychotherapy for the culturally diverse
# Case for AlterNative Therapies

## TABLE 1: Components of Cultural Competence

<table>
<thead>
<tr>
<th>Belief/Attitude</th>
<th>Knowledge</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aware and sensitive to own heritage and valuing/respecting differences.</td>
<td>1. Has knowledge of own racial/cultural heritage and how it affects perceptions.</td>
<td>1. Seeks out educational, consultative, and multicultural training experiences.</td>
</tr>
<tr>
<td>2. Aware of own background/experiences and biases and how they influence</td>
<td>2. Possesses knowledge about racial identity development.</td>
<td>2. Seeks to understand self as racial/cultural being.</td>
</tr>
<tr>
<td>psychological processes.</td>
<td>Able to acknowledge own racist attitudes, beliefs, and feelings.</td>
<td>3. Familiarizes self with relevant research on racial/ethnic groups.</td>
</tr>
<tr>
<td>3. Recognizes limits of competencies and expertise.</td>
<td>3. Knowledgeable about own social impact and communication styles.</td>
<td>4. Involved with minority groups outside of work role: community events, celebrations,</td>
</tr>
<tr>
<td>4. Comfortable with differences that exist between themselves and others.</td>
<td>4. Knowledgeable about groups one works or interacts with.</td>
<td>neighbors, and so forth.</td>
</tr>
<tr>
<td>5. In touch with negative emotional reactions toward racial/ethnic groups and</td>
<td>5. Understands how race/ethnicity affects personality formation, vocational choices, psychological</td>
<td>5. Able to engage in a variety of verbal/nonverbal helping styles.</td>
</tr>
<tr>
<td>can be nonjudgmental.</td>
<td>disorders, and so forth.</td>
<td>6. Can exercise institutional intervention skills on behalf of clients.</td>
</tr>
<tr>
<td>7. Respects religious and/or spiritual beliefs of others.</td>
<td>7. Understands culture-bound, class-bound, and linguistic features of psychological help.</td>
<td>8. Can take responsibility to provide linguistic competence for clients.</td>
</tr>
<tr>
<td></td>
<td>10. Knowledgeable about minority family structures, community, and so forth.</td>
<td>11. Educates clients in the nature of one’s practice.</td>
</tr>
<tr>
<td></td>
<td>11. Knows how discriminatory practices operate at a community level.</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: Adapted from D. W. Sue, Arredondo, & McDavis (1992).*
Case for AlterNative Therapies

A Role for Traditional Healing?

▪ Attitude #8: “Respects indigenous helping practices”

▪ Skill #7: “Can seek consultation with traditional healers”

▪ Traditional healing as the *quintessential form* of “culturally competent” therapy

▪ Principles & approaches to be harnessed?
▪ Lessons to be drawn for MH professions?
Case for AlterNative Therapies

Integration of Counseling & Traditional Healing for AIs

- Early collaborations between MH professionals & traditional healers in MH services *(Attneave, 1974; Bergman, 1973)*

- “Red Road to Recovery” during the 1970s *(Thin Elk, 1993)*

- Classic article in *The Counseling Psychologist* calling for therapeutic integration for AIs *(Lafromboise, Trimble, & Mohatt, 1990)*

- Introduction of “soul wound” psychotherapy *(Duran, 1990, 2006)*


BUT Professional & Indigenous Therapeutic Traditions Can Differ A Lot!
Diverse Therapeutic Traditions

Round 3
Diverse Therapeutic Traditions

- Professional MH Treatments
  - Psychosocial & Psychopharmacological
  - Evidence-Based Practice (EBP) *(Kazdin, 2008)*
    - Empirically-Supported Treatments
    - Client Values & Preferences
  - Clinician Expertise
Professional MH Treatments (cont)

- Empirically-Supported Treatments
  - Experimental demos of causal efficacy using randomized controlled trials
  - Replication of favorable efficacy results across studies
  - Expansion to effectiveness trials to ensure generalizability
  - Incorporation into Clinical Practice Guidelines
  - Dissemination & implementation efforts
Professional MH Treatment (cont)

- Why EBP? *(Gone & Alcantara, 2007)*
  - Need for MH treatments eclipses availability
  - Many MH treatments have not been rigorously evaluated
  - Clinicians believe that their treatments work best
Diverse Therapeutic Traditions

Professional MH Treatment (cont)

- Why EBP? (cont)
  - Clinician (and client) beliefs in efficacy can be mistaken
  - Some treatments have been shown to cause harm

- “Credentialed knowledge” (Meehl, 1997)
Diverse Therapeutic Traditions

Professional MH Treatment (cont)

- Implications of EBP
  - Standardization of approaches or techniques
  - Efficacy depends on technical mechanisms
  - Therapists are (roughly) interchangeable
Professional MH Treatment (cont)

Implications of EBP (cont)

- Therapist expertise is comprised of
  - Technical proficiency
  - Client tailoring

- Fidelity to technique is prioritized over client tailoring

Emphasis on *Technical* over *Relational* (*Gone, 2010*)
Diverse Therapeutic Traditions

- AI Therapeutic Traditions
  - Extremely diverse, some high-order commonalities
  - Northern Plains example
    - Joseph Eagle Elk
    - “The Fish & The Man”

(Mohatt & Eagle Elk, 2000)
AI Therapeutic Traditions (cont)

- A given healer’s ritual protocols may be standardized but recommended treatments often are not

- Efficacy depends on “will/power” of persons involved rather than technical mechanisms

- Healers are not interchangeable but rather remain the single most important therapeutic “variable”
AI Therapeutic Traditions (cont)

- Competent ritual management of associated interpersonal interactions is crucial

- Violations of ritual protocol & ill will among participants are dangerous for patients

- Fear can be an intelligible response to ritual exercises of power

- Emphasis of *Relational* over *Technical* *(Gone, 2010)*
The Nomothetic-Idiographic Distinction

- **Nomothetic**: that which is general across cases & applicable to individuals only in statistical terms

- **Idiographic**: that which is distinctive to a given case & applicable only to a unique individual

- Compare:
  - The nomothetic aspirations of professional MH treatment
  - The idiographic commitments of (some) AI healing practices
The Nomothetic-Idiographic Distinction (cont)

- Could there even be an evidence-based form of such traditional healing practices? *(Gone, 2016)*
  
  - If so, what is gained & lost by evaluating healing in this way?
    
    - Possible Gains: Scientific legitimacy & federal funding
    
    - Possible Losses: Epistemic violence to Indigenous tradition?
  
- If not, what is the relevance of healing for MH treatment?
  
  - Highly relevant even though not evaluable in principle
  
  - Not relevant because not evaluable in principle
The Urban AI
Traditional Spirituality Program

Round 4
Origin of the UAITSP

- Research partnership with regional urban AI health clinic (*Gone et al.*, 2017; *Hartmann & Gone*, 2012; *Wendt & Gone*, 2012a)
  - Incorporation of traditional healing practices into clinic programming
  - Designed for scientific outcome assessment

- Multi-Stage Project
  - Consultation
  - Program Development
  - Implementation
  - Evaluation
  - Dissemination?
Development of the UAITSP

- **Who?**
  Any interested adult members of the metropolitan urban AI community without prior knowledge of experience of these traditions

- **What?**
  Structured orientation to Indigenous spiritual practices

- **Where?**
  At the urban AI health clinic

- **When?**
  One three-hour session per week for 12 weeks (starting in Feb 2016)
Development of the UAITSP

- Why?
  Inaugurate spiritual devotional life for AI participants (with attending wellness outcomes)

- How?
  Socialized participation in the sweat lodge ritual (including key components)
Important Commitments

- Developed “by Indians, for Indians”
- Facilitated by regionally recognized ceremonial leaders (Anishinabe & Haudenosaunee emphasis)
- Man & Woman Co-Leaders (Ideally)
- Record general teachings but not ritual details
- Portable Curriculum (for Replication & Evaluation Purposes)
- Designed in partnership with designated regional ceremonial leader: Mr. Paul Syrette (Anishinabe)
Structure of the UAITSP

- 12 Sessions
  - Program Orientation
  - 4 Sessions of Teachings
  - Sweat Lodge Ceremony
  - 4 Sessions of Teachings
  - Sweat Lodge Ceremony
  - Community Gathering
Structure of the UAITSP

Components

- Intro to ceremony
- Traditional prayer
- Sacred medicines
- Smudging rite
- Gender roles
- Pipe ceremony
- Water ceremony
- Drumming & singing
- Traditional dances
- Sacred fires

- Fasting & visions
- Tobacco ties
- Talking circles
- Approaching an elder
- Give-aways
- Feasts & traditional foods
- Language & ceremony
- Medicine pouches
- [Drug & alcohol abuse]
- Honor songs
Structure of the UAITSP

- Regular Reminders
  - Tolerance for cultural diversity
  - Positive attitudes, Open minds & hearts
  - Respect for women’s cycles
Prospects for the UAITSP

Targeted Wellness Outcomes

- Enhanced cultural ID, spirituality, ceremonial knowledge, & cultural involvement
- Increased community-mindedness, coping skills, social support, help-seeking attitudes
- Greater life satisfaction, reduced distress/symptoms, improved emotion regulation
Prospects for the UAITSP

Future Directions

- Refinement
- Funding
- Evaluation
- Dissemination
Closing
AIs suffer from MH inequities in dire need of remedy

The MH professions prescribe EBP as the most effective means for redressing these inequities

AI communities often propose instead to harness traditional therapeutic practices for MH problems

The question of “what works” reveals clear divergences in professional & Indigenous knowledge practices that are difficult to fully reconcile

It may be possible to develop programs based on Indigenous traditions that can be evaluated
For more information & to download my publications, visit my website at:
gonetowar.com