

Mental Health Services for Native Americans in the 21st Century United States

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As the population of American Indians and Alaska Natives continues to expand in the 21st century United States, an increasing number of professional psychologists will be called upon to provide culturally appropriate mental health services for Native American people and their communities. This article provides a general overview of contemporary tribal America before describing the legal, political, and institutional contexts for mental health service delivery administered through the federally sponsored Indian Health Service. Recommendations for mental health professionals who desire to avoid a subtle but profound Western cultural proselytization in their therapeutic service to Native clients and their communities are presented.

It is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all the resources necessary to effect that policy. (Pub. L. No. 94-437, §3a)

Since 1976, with congressional passage of Public Law 94-437, better known as the Indian Health Care Improvement Act, the supreme law of the land has been to realize the “highest possible health status” for this nation’s small but vibrant population of Native Americans. Ambiguous goals frequently frustrate ambitious agendas, however, and as the country moves toward a fourth reauthorization of this landmark legislation—the legal capstone bolstering federal provision of health care services to American Indians and Alaska Natives—actual congressional allocations to the Indian Health Service (IHS) remain only 52% of that required to ensure adequate “personal health services” for today’s tribal citizens (Federal Disparity Index Workgroup, 2002). If health care services in general suffer from such intimidating fiscal constraints, then mental health services in particular bear a disproportionate share of this budgetary burden, with less than 7% of IHS funding designated for “behavioral health” and substance abuse treatment services combined (National Indian Health Board, 2002). Thus, despite the surgeon general’s recent call for interventions in American Indian and Alaska Native communities (also referred to as Indian country) that “promote the strengths, resiliencies, and other psychosocial resources that characterize full, productive, and meaningful lives” (U.S. Department of Health and Human Ser-

vices, 2001, p. 97), the sad reality is that the mental health needs of this nation’s Native American citizens remain largely overlooked and ignored.

In this article I provide a detailed update concerning mental health services designated for American Indians and Alaska Natives, and I recommend several future directions that might result in improvements in mental health service delivery to these populations. Before proceeding to these tasks, however, I provide a more systematic overview of contemporary Native America.

Tribal America in the 21st Century United States

Tribal America in the contemporary United States consists of roughly 560 federally recognized tribal governments representing approximately 1.4 million tribal citizens (U.S. Department of the Interior, 2002). These distinctive political communities are the contemporary remnants of over 5 million indigenous inhabitants of the contiguous United States prior to European contact in the late 15th century (Thornton, 1987). Early historical alliances between Native peoples and colonial settlers were later codified in several hundred treaties—legal instruments testifying to the international status of such agreements—that typically involved the cession of Indian land in exchange for American promises to offer amity, protection, goods, and services.

American expansionism, sustained by the conviction of Manifest Destiny, soon overwhelmed such assurances, and no treaty was left unbroken as the U.S. Army engaged in a long series of military campaigns aimed at finally resolving America’s longstanding “Indian problem” (Utley, 1984). With the closing of the American frontier in 1890 following the massacre of Lakota non-combatants at Wounded Knee, a discourse of civilization came to prevail over a discourse of conquest within U.S. Indian policy as large numbers of Indian children were forcibly educated in “Christian” ways at government and religious boarding schools (often far removed from their homes and families). The goal of such education was made explicit in the words of Captain William Henry Pratt, founder of the prototypical off-reservation Indian boarding school at Carlisle, Pennsylvania: “Kill the Indian in him and save the man” (Adams, 1995, p. 52). By the close of the 19th century,

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America's indigenous population had declined to just 250,000 persons. Thus, having survived dangers both ideological and mortal, contemporary Native peoples remain heirs to the shattering legacy of a brutal Euro American colonialism.

According to the most recent U.S. Census (U.S. Census Bureau, 2002b), 2.5 million Americans identified themselves as American Indian or Alaska Native, considerably more than the number of tribal citizens served by the federal Bureau of Indian Affairs—clearly, many Americans consider themselves to be Native American despite their lack of political citizenship in federally recognized tribes. There are several reasons for this complex phenomenon, ranging from the arbitrary and arcane politics of federal recognition to the popularity of all things Indian among New Age “wannabees.” In reality, the number of Americans who might legitimately lay claim to Native American identities—including members of over 200 state-recognized tribes who might one day qualify for federal recognition, Black-Indian descendants of mixed-blood freedmen who were historically disenfranchised by their own (formerly slave-holding) tribal communities, or the multitribal offspring of tribal citizens who ironically do not qualify for enrollment in any single tribe themselves—must figure somewhere between the two extremes, perhaps encompassing some 2 million persons (for a more detailed discussion of the ambiguities of Indian identity, see Gone, in press-b).

Nevertheless, there are compelling reasons for privileging the legal and political status of individual tribal members over “racial” ancestry, cultural fluency, or personal identification owing to the distinctive federal services context established for the citizens of federally recognized tribal governments. More specifically, such tribes sustain a unique “government-to-government” relationship with the United States that depends principally upon established legal interpretations of the significance of historical treaty making. Thus, these tribal groups have been accorded the unprecedented legal status of “domestic, dependent nations” for which the United States maintains a “general trust relationship” implying a “duty of protection” (see Pevar, 2002, for much more detail). Currently, this Trust Responsibility encompasses the provision of health care—including mental health care—to federally recognized tribal communities in accordance with the Indian Health Care Improvement Act of 1976 (and its subsequent reauthorizations). The federal agency primarily responsible for providing such services to Native people is the IHS, a branch of the U.S. Public Health Service that operates or funds approximately 150 “service units” distributed throughout Indian country; 80% of these most basic administrative health care units include mental health programs (IHS, 2002b).

Beyond the profound legal and political circumstances that distinguish Native Americans from any other U.S. ethnic minority group, what else might be concluded about American Indians or Alaska Natives in comparison with other Americans? First, it is crucial to recognize that the terms *Native American*, *American Indian*, and *Alaska Native* are “ethnic glosses” (Trimble, Helms, & Root, 2002) that heuristically denote contemporary descendants of America's aboriginal peoples while simultaneously obscuring terrific cultural and linguistic diversity. Today's Native Americans practice numerous religious traditions (both indigenous and Christian), speak dozens of languages (both ancestral and English), and reside in hundreds of communities (both reservation and urban) throughout the United States. Thus, the term *Native American* can be conceptually likened to the term *European* in that the social,

political, and economic diversity of the referent always comes readily to mind. One difficulty of offering a review of mental health issues in Native America, then, is that no description of any modal Indian community or experience can accurately reflect the diversity of what would otherwise seem to be a tiny subpopulation (less than 1%) of the American demographic landscape.

If one keeps such variation in mind, it does seem from the best available (albeit limited) data that modern Native Americans compared with the equally elusive modal American are in general younger (median age of 28.7 years vs. 35.3 years for the general U.S. population), poorer (24.5% in poverty with median income of \$32,116 vs. 11.7% in poverty with median income of \$42,228), less educated (71% high school graduates with 11% of adults holding a bachelor's degree vs. 80% high school graduates with 24% holding a bachelor's degree), and less healthy (death from alcoholism 770% greater, tuberculosis 750% greater, diabetes 420% greater, accidents 280% greater, and suicide 190% greater in Native American populations than in Americans in general). In addition, nearly half of the Native population lives in the American West, with some 500,000 Indians living on or near reservations—thus, the majority of contemporary Native Americans reside in towns and cities where employment, housing, and educational opportunities are more abundant. For example, some 50,000 Indians live in Los Angeles alone (U.S. Census Bureau, 2002a). The reader should keep in mind that many of these statistics (see IHS, 2002a, 2002b; U.S. Census Bureau, 2002b) are based on samples that include large numbers of nonenrolled, self-identified Native people that in all probability skew the results toward mainstream averages. Actual citizens of federally recognized tribes are probably distributed somewhat further from the American mean on most of these social indicators.

Contemporary Mental Health Services for Native Americans

In this section, I first provide a general overview of mental health services for American Indians and Alaska Natives and then briefly describe the contours of one particular service delivery system within a specific tribal community.

A National Overview

The principal provider of mental health and substance abuse treatment services specifically targeted for American Indian and Alaska Natives in the United States is the IHS (whether administered directly or through tribally contracted or tribally compacted programs). An Office of Mental Health was first established within the IHS in 1965 with an annual appropriation of \$500,000. Today, with a budgetary appropriation of over \$180 million (National Indian Health Board, 2002), roughly 1.5 million Indian people are eligible for IHS-funded mental health and substance abuse treatment programs, including those offered at more than 30 urban Indian health projects in cities (IHS, 2002b) that were once official destinations for federally sponsored “relocation” programs (initially implemented to facilitate family transition from reservation to city life).

Like other Americans, Native people might also qualify for mental health services through the usual variety of other venues: state and county public health clinics and programs, HMOs, and

private or independent service providers who accept Medicare/Medicaid or personal insurance reimbursements. Because many Indian families contend with poverty and unemployment, however, a disproportionate number are uninsured or underinsured (Brown, Ojeda, Wyn, & Levan, 2000) and are therefore unable to afford quality mental health services requiring nonfederal third-party payment. In any case, it remains exceedingly unlikely that the vast majority of these “mainstream” services—even when actually accessible to Native people—are capable of providing “culturally sensitive” assessment and treatment (i.e., services that are intentionally formulated to assist Indian clients). Thus, the “behavioral health” and substance abuse treatment programs sponsored by most IHS service units remain the primary access points for Native people—60% of whom rely on the IHS for their health care (IHS, 2002a)—to obtain psychological services in times of distress (for a more thorough review of Indian health and mental health issues in the context of IHS policy and practice, see Gone, 2003).

Unfortunately, as I mentioned previously, the IHS is woefully underfunded with regard to providing truly adequate services. And with only 7% of the IHS budget devoted to mental health and substance abuse treatment services, these areas are particularly shortchanged. Within its behavioral health programs specifically (because most substance abuse treatment programs are contracted for direct administration by tribal governments), IHS employs some 300 full-time staff members, two thirds of whom are licensed (or licensable) clinicians. Of the roughly 20 psychiatrists, 60 psychologists, and 110 social workers working in the behavioral health clinics, many are themselves Native American (although only 2 of the psychiatrists and 17 of the psychologists are Indian; J. Davis-Hueston, personal communication, June 22, 2001). These personnel were expected to provide clinical services at the annual rate of 208,000 “client contacts” (or assessment and treatment sessions) during the 2001 fiscal year.

Valid data on the precise activities of these clinicians are not available, but it seems from anecdotal accounts that the vast majority of these client contacts comprise individual psychotherapy sessions spanning a range of therapeutic orientations. Certainly, consultations with regard to the prescription of psychotropic medications are not uncommon either, although this activity is most likely undertaken by general practitioners owing to the shortage of psychiatrists in the system. Given the 1.5 million Indians currently eligible for IHS-funded services, the behavioral health programs employ approximately 2 psychiatrists and 4 psychologists per 100,000 people (in contrast to general U.S. availability of 14 psychiatrists and 28 psychologists per 100,000 people; see West et al., 2000). Extrapolating further, and assuming an arbitrary number of 3 individual sessions or “contacts” per client annually (a conservative estimate with questionable therapeutic utility), one can see that the 208,000 client contacts that all IHS behavioral health clinicians were expected to provide in 2001 would have benefited roughly 70,000 Native persons, or less than 5% of the IHS service population.

The significance of this final extrapolation depends entirely upon the actual need for specialty mental health services within the American Indian and Alaska Native communities served by the IHS. Unfortunately, methodologically sound data regarding the incidence and prevalence of psychiatric disturbance and attendant service utilization are extremely difficult to obtain. Within a

broader societal context, the National Comorbidity Survey (Kessler et al., 1994) recorded at least one lifetime disorder (according to criteria of the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 1987) for 48% of the American adult population, including alcohol dependence among 14% and major depressive episodes among 17% of the adult population. Furthermore, Kessler and his colleagues determined that 29% of the adult population suffered from diagnosable psychiatric distress within the one-year period immediately prior to the assessment. In addition, over 50% of those reporting psychiatric disorders qualified for more than one lifetime diagnosis. Finally, and most significantly, only 40% of those ever experiencing a mental disorder within their lifetimes reported receiving professional treatment for their difficulties.

Comparable epidemiologies of psychological distress among American Indians and Alaska Natives have not yet been published. A handful of existing community-based studies (see Roy, Choudhuri, & Irvine, 1970; Sampath, 1974; Shore, Kinzie, Hampson, & Pattison, 1973 [cf. Kinzie et al., 1992, for a replication of the latter]) certainly suggest that the prevalence of psychiatric disorder—especially mood and substance use disorders—are atypically high in these Native communities, but their dated methodologies render them difficult to interpret (see O’Neill, 1989, for a review and critique).

A more recent report commissioned by the Senate Select Committee on Indian Affairs (U.S. Congress, Office of Technology Assessment, 1990) concluded that Native American adolescents were at increased risk for a host of psychological problems when compared with non-Indian adolescents, including substance abuse, clinical depression, and suicide. In contrast, however, the Great Smoky Mountains Study (Costello, Farmer, Angold, Burns, & Erklani, 1997) surveyed Indian and White youths between 9 and 13 years of age in Appalachia and found quite similar rates of mental disorders, though Native youths were up to 10 times more likely to abuse alcohol at these early ages. These reports support the conclusion that American Indian and Alaska Native communities contend with higher rates of psychological dysfunction than do their mainstream counterparts, especially in the areas of substance abuse, clinical depression, posttraumatic stress, domestic violence, and suicide.

Recently the prevalence of psychiatric distress within two large American Indian communities was assessed by researchers in the Division of American Indian and Alaska Native Programs at the University of Colorado Health Sciences Center, where Manson and his associates will soon publish the results of their methodologically sophisticated American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (for a preliminary report, see Beals, Manson, Mitchell, Spicer, & the AI-SUPERPPF Team, 2003). In the meantime, professionals must be content with the observation that the resources available for addressing the mental health needs of American Indians and Alaska Natives through the IHS (and probably every other relevant service delivery venue as well) are as scarce as the need is both palpable and pressing (for a more in-depth review and summary of the issues, see chapter 4 of the Surgeon General’s recent report on race and mental health [U.S. Department of Health and Human Services, 2001] and Manson, 2000).

A Local Illustration

I offer as a counterbalance to the many generalities already reviewed here a concrete example of mental health service delivery within the IHS health care system on the Fort Belknap Indian reservation in north-central Montana. Home to my own Gros Ventre and Assiniboine ancestors, Fort Belknap encompasses 40 miles of rolling prairie from the Milk River in the north to the Little Rocky Mountains in the south and spans 25 miles east to west. Four small communities dot the landscape of the reservation, including the Fort Belknap Agency in the northwestern quadrant, where the tribal headquarters and government agencies are situated. Fewer than half of the 5,000 members of both tribes reside on or near the reservation, though it is not unusual for tribal members to circulate to the nearby towns and cities in search of housing, employment, or training, only to return as fortunes change or family responsibilities dictate. The impressive IHS clinic at the Fort Belknap Agency was constructed during the mid-1990s to serve as the headquarters for both IHS and tribal health programs; a smaller satellite clinic operates simultaneously in the tiny community of Hays to better serve reservation residents of the Hays and Lodgepole communities to the south. Still, for some health care services, reservation residents may be required to travel up to 60 miles from the outlying communities into the agency clinic and sometimes an additional 45 miles west to the nearest hospital in Havre. In cases requiring specialized or emergent care, it is not uncommon for tribal members to travel 150–200 miles to the Great Falls or Billings medical centers, by ambulance or Medivac helicopter when necessary.

Although the Fort Belknap Community Council contracts with the IHS to administer many federally sponsored health care programs directly, most clinical services remain under the purview of the IHS, which recruits and employs the physicians and other service providers and directs their work (albeit in consultation with the tribal council). Similarly, the reservation's "behavioral health" services are administered directly by the IHS, though the substance abuse treatment program has been administered via contract by the tribe for many years. During a recent summer visit, I observed that the IHS service unit at Fort Belknap employed three full-time clinicians to staff its behavioral health program, including two clinical psychologists and one social worker; none of these licensed professionals was Native American, and one was preparing after nearly 3 years of service at Fort Belknap to relocate to an IHS clinic in another state to be closer to city life. Similar reassignments or resignations of health care professionals are not uncommon at Fort Belknap, and professional staff turnover within the IHS system is seemingly endemic to this "hyper-rural" outpost.

Not surprisingly, the quality and commitment of the clinicians who circulate through the community can vary widely. For example, I have not forgotten the first IHS mental health professional at Fort Belknap with whom I became acquainted because he inaugurated a support group comprised entirely of community members with the sober assurance that even though he could lay no biological claim to Indian heritage, he had at least been an Indian "in a former life." Of course, most IHS service providers are more conventional in their professional conduct and demeanor, but the system is not immune to such aberrations. In addition to the clinical staff, the program also employed a full-time secretary to manage appointments and run the office. Finally, I should note that

a single IHS psychiatrist consults on pharmacological issues for the eight behavioral health programs on the reservations in the Montana–Wyoming area, including Fort Belknap; thus, medication management is frequently handled by the more readily available general practitioners between the monthly visits of the itinerant psychiatrist.

In terms of clinical activity, the Fort Belknap behavioral health program provided over 300 service hours per month in the individual assessment and treatment of (principally) clinical depression, posttraumatic reactions (related in many instances to childhood abuse), and crisis intervention among both adults and young people. Many of the patient contacts involved just two to three visits in the context of a personal or family crisis before the clients were "back on their feet." It is not uncommon, however, for a community member to seek assistance during a time of crisis and request an appointment with program staff over the phone, only to skip the meeting later because the typical appointment could not be scheduled for at least 2 weeks, and by then the crisis had passed.

Substance abuse was also a concern for many clients, but the behavioral health program depends upon the tribally administered substance abuse treatment program for clinical progress in that area, and coordination of treatment between the IHS behavioral health program and the tribally administered substance abuse treatment program on behalf of clients with "dual diagnoses" was largely nonexistent. Keep in mind, too, that a sizable number of the program's clientele were ordered to treatment by the tribal court in the context of related legal proceedings. Of special significance was the explicit commitment of the behavioral health program to work with distressed youths both within and outside of the clinical setting, with school-based outreach remaining a high priority.

In sum, the provision of health care services—including mental health services—to American Indians and Alaska Natives who are enrolled in federally recognized tribes remains a moral and legal obligation of the U.S. federal government in accordance with its Trust Responsibility to tribal nations. Owing to chronic budgetary constraints, recruitment and retention challenges, and routine cultural misunderstanding, the assertion that American Indians and Alaska Natives are "underserved" with regard to mental health care in the United States glibly understates a national travesty that demonstrates an intrinsic but ongoing repudiation of America's longstanding Trust obligations to tribal nations.

Future Directions for Enhancing Mental Health in Tribal America

Undoubtedly, the preceding discussion has inspired many readers to formulate ways in which to improve mental health service delivery within American Indian and Alaska Native communities. Indeed, if the need so quickly surpasses the available resources, then a large part of the solution would seemingly be to amplify, extend, and multiply the mental health resources earmarked for Indian country. Certainly the IHS and the National Indian Health Board (2002) routinely lobby the U.S. Congress for increased appropriations in an effort to dissolve the many troubling disparities in health care outcomes for Native people (IHS, 2002a). Of course, the key to success for many advocacy and policy initiatives targeted at governmental institutions and agencies is to provide compelling scientific data with which to bolster the case. As we have seen, however, such data concerning Indian mental health are

few and far between (notwithstanding the prolific and sustained efforts of the research network associated with the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center).

In addition, in such instances in which the demand for community-tailored mental health services far exceeds the supply of capable and knowledgeable professionals, it seems only reasonable to train more service providers by tailoring their ambitions and targeting their skills for working in Native communities. During the last decade, for example, a handful of clinical psychology training programs accredited by the American Psychological Association (APA)—mostly in the western rural states of Montana, the Dakotas, Utah, and Oklahoma—have developed specialized “Indians into Psychology” tracks (some of which are federally funded through the 1992 reauthorization of the Indian Health Care Improvement Act of 1976; see § 217 of Pub. L. No. 102-573) oriented toward recruiting, retaining, and graduating Native doctoral students for future service in Indian country. Indeed, the graduates of these programs are swelling the ranks of the 150 or so Native psychologists to have earned their credentials during the latter half of the 20th century (APA, 2001). Finally, there now exists a cadre of Native psychologists who have elected to pursue careers in academic research, hoping to collectively redress the absence of a robust empirical literature on Native American mental health.

Thus, in charting the future of mental health services for Native Americans in the 21st century United States, I wish I could conclude that all is well. In fact, though, I harbor a central misgiving regarding many of these noble efforts, which goes straight to the problem of culture in the psychologist’s clinic (and, by extension, in the psychologist’s classroom; see Gone, in press-a). Indeed, if my experiences at the annual conference of the Society of Indian Psychologists are at all representative, the predicament of culture confronts the majority of us who are situated at the intersection of professional psychology and the American Indian community. And, most strikingly, it resounded clearly during my recent investigations at Fort Belknap, in which I sought a more nuanced understanding of the cultural implications of conventional mental health service delivery for Fort Belknap tribal members.

For example, during one memorable interview with a tribal elder concerning the relationships between history and culture on the one hand and problem drinking and depression on the other, I inquired as to the circumstances under which he might consider referring a loved one to the behavioral health program at the Fort Belknap IHS clinic. With soft words—underscoring the seriousness of his convictions on the matter—Winston (a pseudonym) replied:

That’s kind of like taboo. You know, we don’t do that. We never did do that. 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] [W]hite psychiatrists in the Indian Health Service and say, “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.

Because we as mental health professionals—even those of us who belong to communities indigenous to this continent—have invested a great deal of time and energy in completing our training and establishing our credentials, it remains exceedingly difficult for us to concede to this unusually reflective tribal member that our most prevalent therapeutic technologies and techniques may actually harbor risk in the form of cultural displacement and assimilation for many tribal communities. And yet, given the cultural origins of most conventional clinical practices—grounded in and emerging from the “Western” traditions of individualism, dualism, and secular modernity—is it really so difficult to imagine that IHS clinicians are, in several quite crucial respects, subtly and inadvertently prescribing Western selves (or, more accurately, subjectivities) through their therapeutic ministrations to their distressed Indian “clients”? Could it be that Winston is right—that conventional mental health services in Indian country involve a subtle but significant form of cultural “brainwashing”?

The implications of such unsettling considerations for professional psychology are undoubtedly profound, for they suggest that any substantive commitment to cultural preservation and revitalization within contemporary tribal communities—which are, we must not forget, still recovering from the shattering effects of Euro American colonialism—requires a serious reorientation to our business of promoting mental health and preventing psychological dysfunction. Indeed, the principal challenge for us is to “begin before the beginning”—that is, to jettison (or, at least, to keep at bay) a host of professional assumptions, convictions, attitudes, beliefs, and conventions surrounding our disciplinary consensus regarding the desirable attributes of “mental health” to formulate much more subtly and rigorously, in culturally local terms, the contours of wellness and dysfunction that would enable us to develop rich, culturally consonant alternatives to mental-health-services-as-usual. In sum, before we can presume to know how to help Native communities in culturally appropriate ways, we must first study the cultural underpinnings of wellness from the perspective of contemporary community members.

Volumes have been written, of course, issuing the call to a multiculturally sensitive psychotherapy (see Sue & Sue, 1999, for a classic example). In the rush to serve distressed American ethnic minority clients more effectively, however, very few of these treatises consider the full implications of psychotherapy as a thoroughly enculturated practice—not simply in its superficial and overt conventions (e.g., that matching therapist and client by race, class, or gender can improve therapeutic outcomes; that factoring the acculturation level of the client into treatment planning can improve therapeutic efficiency; that requiring non-English language proficiency among service providers is essential to treating “ESL clients”; that determining the kind and number of persons to involve in the therapy is directly related to client progress; that tailoring the style of communication and interaction between therapist and client is important therapeutic practice; etc.), but also in its constituent and covert presumptions (e.g., that good “mental health” is a valued end state worth investing time, energy, and money to pursue; that intrapsychic exploration, insight, and expression benefit those who suffer; that talk is a principal means of achieving desirable emotional or psychological states; that the best people to turn to in times of trouble are secular professionals credentialed through doctoral training and licensure; that specialized assistance for psychological difficulty should be obtained

separately from other forms of help; etc.). The extant multicultural critique of psychotherapy seems readily prepared to alter, shape, or tailor clinical conventions in an effort to create new “best practices” for service to ethnic minority clients *without* seriously considering whether retaining psychotherapy as a mode of practice altogether might not still result in undesirable—perhaps even in politically indefensible—proselytization of the “culturally different” to Western norms of subjectivity (e.g., a subtle socialization into Western notions of appropriate emotional experience and expression).

There is, of course, a great deal more that might be conveyed regarding these concerns (see Gone, 2003, for an in-depth discussion), but for now I conclude with a series of recommendations for clinicians desiring to be mindful of these considerations while directly confronting the prospect of serving Native American clients and communities. We must be guided by four principles as we attempt to cultivate modes of inquiry that proactively assess and surmount the dangers of a nearly invisible (but potentially countertherapeutic) “cultural proselytization” of psychotherapy clients in Indian country (and perhaps in cross-cultural encounters or in non-Western settings more generally). The specifics of such an endeavor should minimally include the following:

1. *Keep Culture in Mind*

The recent “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists” (APA, 2003) provide a reasonably comprehensive overview of the multicultural endeavor within the profession and explicitly prescribe a reflexive commitment by psychologists to “cultural awareness and knowledge of self and others” (p. 382). Awareness of one’s own deeply embedded cultural assumptions is often quite elusive unless or until one encounters others whose shared (i.e., collective, as opposed to idiosyncratic) sense of what is true, good, right, proper, and beautiful collides with one’s own. Such cross-cultural collisions are likely to be more frustrating than illuminating, however, unless one is fairly committed to excavating the intelligibility of unfamiliar cultural practices (e.g., adolescent female circumcision in sub-Saharan Africa vis-à-vis infant male circumcision in the United States; see Shweder, 2002). In the absence of such a commitment, however, the proclivities and habits shared by one’s own community are likely to seem “natural” instead of cultural—and thus universal instead of local—in their applicability. The obvious implication here is that although all psychologists would benefit from the searching reflexivity prescribed by the Guidelines, cultural self-awareness is absolutely mandatory for professionals aspiring to work with Native American clients and communities.

Furthermore, even though the Guidelines emphasize the significance of cultural self-knowledge for multiculturally sensitive professionals, their discussion of therapeutic techniques, practices, and interventions as culture-laden tools employed by such professionals is less satisfying. We must remember that the modern psychotherapies are cultural “artifacts” (i.e., cultural creations or products situated within a unique time and place) whose mechanisms and meanings emerge from and depend upon the cultural intelligibility of their operations to both therapist and client. As cultural artifacts, the modern psychotherapies can be studied in terms of their historical origins and evolution within the West, as

well as in their adoption and adaptation throughout the world. For example, Cushman (1995) has written a fascinating account of the cultural history of psychotherapy in America that illuminates the broader societal contexts that render psychotherapy practices viable in the contemporary United States. Thus, it is incumbent upon all mental health professionals working in cross-cultural contexts, including in Indian country, to be reflexively aware of the origins, assumptions, and predispositions of their particular therapeutic orientations and practices. In short, it is necessary for us to recognize the cultural constituents of our own training and technique, including any received notions of wellness, distress, disorder, and healing—this is incumbent upon us not only as enculturated persons but also as *enculturated professionals*.

Fortunately, reflexive awareness of the cultural foundations of professional practice is rather readily obtained through simple comparison with other documented healing traditions around the world. In the context of my own community, I usually recommend perusal of the published biography of our most famous medicine person, Bull Lodge, for insight into ancestral Gros Ventre healing tradition (Gone, 1980). Comparison of Bull Lodge’s calling, credentialing, and career activities with the efforts of the modern psychotherapist reveals obvious divergence in the origins, assumptions, meanings, and mechanisms of these rather disparate healing traditions.

2. *Keep Culture in Mind*

In addition to recognizing the modern psychotherapies as cultural artifacts, mental health professionals aspiring to be of service in Indian country also must attend to the cultural contours of mind, self, and personhood across societal contexts. Any commitment to the application of the modern psychotherapies cross-culturally presupposes an empirical basis to guide substantive innovations that might better serve targeted clients. An increasingly influential interdisciplinary tradition with clear relevance here is the reemerging field of cultural psychology (Bruner, 1990; Cole, 1990; Shweder & Sullivan, 1993). Cultural psychology takes as its conceptual point of departure the co-constitution (i.e., interdependent existence) of culture and mind (Shweder, 1990). Its central locus of inquiry therefore concerns the *meaningful* (i.e., semiotic, symbolically mediated, or “meaning-full”) nature of all human experience. The careful formulation of local ethnopsychology within the framework of cultural psychology thus encompasses multiple relevant content areas, including the complex relationships between culture, language, and mind; the experiential foundations of self and personhood; the nuanced diversity of emotional experience and expression; the conceptual underpinnings of health, illness, and healing; and research reflexivity (i.e., attention to how the knower constructs the known). Each of these phenomena contains important implications for exporting modern psychotherapies to American Indian and Alaska Native communities.

Obviously, the careful formulation of an indigenous ethnopsychology is most relevant for professional psychologists working not just with an occasional American Indian client but with an actual Native community. This is true not only because the effort required to familiarize oneself with the cultural psychology of a given community is extremely time-consuming but also because the diversity of Native America limits the ability to generalize across the experiences of Indian clients from different communi-

ties. As a result, it is rather difficult to offer specific advice to professional psychologists desiring to assist an occasional Native client. Although several previous reviews offer helpful recommendations to practitioners for treating American Indian clients in general (LaFromboise, Trimble, & Mohatt, 1990; Trimble, Manson, Dinges, & Medicine, 1984; Trimble & Thurman, 2002), there is simply no such thing as a “Generokee” (i.e., generic American Indian) ethnopsychology available to guide the work of clinicians in such circumstances in any specific way. Thus, a clear logistical advantage lies in the professional commitment to serving an American Indian *community*.

In the context of a community-based practice, then, professional psychologists have several means of exploring and identifying key aspects of the local ethnopsychology. First, psychologists should insist that part of their initial professional efforts include time for community outreach, during which they might participate in community activities and events and consult with ritual leaders and cultural authorities regarding the role of psychologists as service providers in the community. In addition, psychologists should peruse the anthropological literature originating in the community—soliciting recommended sources from community members themselves—in an effort to identify important facets of the local ethnopsychology (see, e.g., Strauss’s [1977] report on Northern Cheyenne ethnopsychology or Anderson’s [2001] treatment of Northern Arapahoe personhood). Finally, after consulting carefully with community leaders on the matter, psychologists might consider inviting a cultural anthropologist from a nearby college or university to consult with the clinic on matters of ethnopsychology and healing.

3. Develop, Implement, and Evaluate Therapeutic Efforts Collaboratively

Once the parameters that circumscribe the applicability of standard clinical intervention have been identified (with appropriate attention to local culture and ethnopsychology), the systematic development, implementation, and evaluation of novel and ongoing therapeutic efforts should proceed in close collaboration with key community members in Indian country. Given that much of Native America views disorder and healing in the context of spirituality and religious practice, local consultation with medicine persons, ritual leaders, and even Christian clergy may be essential to the successful implementation of any form of psychotherapeutic practice (whether novel or conventional). Furthermore, the enlistment of a variety of active healers and other “natural” helpers from the community would afford a degree of insight into the culturally salient interventions already practiced in the community and would also allow for a joint analysis of the validity, viability, and effectiveness of novel forms of therapeutic intervention in unfamiliar cultural contexts. Finally, I should add that close collaboration with community members may be the only means of determining which of the cultural transformations wrought by psychotherapy are welcomed in the interest of help and healing and which are seen as undesirable or inappropriate in local cultural contexts. Only through such close collaboration can the subtle logistical dangers of neocolonialism be overcome.

This call to collaboration for professional psychologists serving Indian country underscores the significance of *ongoing* consultation with community members regarding nearly every facet of

clinical activity. If this collaboration is taken seriously, the result is likely to be a new kind of behavioral health clinic that allocates a substantial portion of its resources to the interface between the clinic and the community to maximize the relevance, efficiency, and utility of the services it provides. Clearly, the professional psychologist employed in such a setting will assume many responsibilities beyond the conventional role of psychotherapist—experience in community relations, creative administration, program development, clinical supervision, outcome assessment, and grant writing would help to ensure the success of such a collaborative endeavor.

Of course, such work would seem all but impossible within the organizational structures of a conventional psychological clinic. Given the possibilities for tribal assumption of mental health service delivery, it remains plausible that behavioral health services in Indian country might emulate the many tribally controlled substance abuse treatment programs whose administrative structures are intentionally designed to facilitate the creative integration of culture and community into their efforts. Such arrangements typically result in the *institutionalized* consultation of ritual and cultural authorities, who are respectfully compensated for their expert contributions in the form of curriculum development, case management, mutual referral, intervention analysis, and so forth.

4. Assess Process and Outcome More Comprehensively

The obvious question confronting professional psychologists in Indian country is whether their interventions are accomplishing genuinely therapeutic effects. That is, given the frequent and pervasive possibilities for cross-cultural dissonance of every sort, careful attention to therapeutic outcomes in Native America is obviously warranted. In addition to tracking outcome, many psychologists are also familiar with the assessment of psychotherapy process, a research strategy with obvious promise for cultivating a more comprehensive understanding of the effectual mechanisms inherent to clinical intervention. Given the kinds of therapeutic innovations that will result from collaborative implementation efforts in Native communities, the assessment of effects—both therapeutic and countertherapeutic—throughout the course of intervention must be both rigorous and extensive.

For example, in addition to tracking the presumed or desired outcomes of these “translated” or “adapted” therapies, professional psychologists in Indian country must also attend more comprehensively to the miscommunications, standoffs, breakdowns, and failures in the course of therapeutic intervention, because such mishaps may signify subtle and implicit incommensurability between therapeutic models and local ethnopsychology. Furthermore, posttherapy outcome assessments should include attention to the impressions and opinions of the clients’ significant others regarding the kind and extent of therapeutic benefits obtained; such attention will help to illuminate the broader cultural consequences of therapeutic socialization for clients, their families, and their communities.

In short, professional psychologists committed to serving Native American communities must dust off their research skills in order to chart therapeutic process and assess therapeutic outcome. When resources are limited, this might simply involve thorough note taking following each session and the pre- and posttherapy administration of paper-and-pencil symptom checklists and rating scales

(with a brief follow-up assessment some months later). Brief analysis of these data may illuminate patterns of clinical response over time. When resources are greater, more rigorous designs affording additional precision and control could yield results that effectively reduce the range of competing explanations for observed phenomena. In sum, practicing psychologists undertaking innovative therapeutic activities with American Indian clients and communities must never forget their profession's commitment to testing suppositions, expectations, and explanations empirically. The foundation of competent professional practice is a robust clinical psychological science.

As should by now be obvious, the prescribed regimen for therapeutic practice in American Indian and Alaska Native communities is not especially well-tailored to the institutional realities of conventional health care service delivery. Nevertheless, the consequences of proceeding as if the cultural transactions that occur within the therapy session in Indian country are trivial may signal an unacceptable return to an all-too-easy and familiar colonizing dynamic by the very individuals who are both ethically and professionally charged with facilitating the robust mental health of *all* of their clients, regardless of their race, ethnicity, or cultural origin (APA, 1990, 2003). In the end, there can be no question that those of us with professional responsibilities in the field of Native American mental health confront both substantial challenges and rare opportunities. Thus, to surmount the challenges and master the opportunities before us, we must think beyond convention and work tirelessly to provide Native communities with fully accessible, culturally appropriate, and demonstrably effective programs and interventions that only innovative and culturally informed psychologists can create and sustain.

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Received March 28, 2002

Revision received September 11, 2003

Accepted September 16, 2003 ■

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