



The (Post)Colonial Predicament in Community Mental Health Services for American Indians: Explorations in Alter-Native Psy-Ence

Joseph P. Gone

Department of Anthropology, Harvard University

Department of Global Health and Social Medicine, Harvard Medical School

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Early in my career, I explored clinical depression and problem drinking among my own American Indian people on the Fort Belknap Indian reservation in Montana in the United States. There I interviewed a middle-aged cultural traditionalist named Traveling-Thunder who explained why many community members struggled with substance abuse and associated distress. In his view, the primary problem was that “we do not fit in with the Whiteman’s system.” As it turned out, this straightforward observation captured an entire explanatory rationale about reservation mental health that reappears everywhere I go in “Indian Country.” Specifically, Traveling-Thunder highlighted history and spirituality in his account of the emergence of community mental health problems, overtly attributing these forms of disabling distress to processes of Euro American colonization. This problem frame overtly recasts “mental disorders” as (post)colonial pathologies, which anchors a broad alter-native Indigenous mental health discourse. This framework is parallel to but distinctive from dominant psychiatric discourse. In this article, I describe this alter-Native psy-ence and trace the implications for American Indian community mental health services.

Public Significance Statement

Community mental health research among American Indians reveals an alternative framework for mental health concerns that is parallel to but divergent from professional discourse. Consideration by psychologists of this framework is important if relevant, accessible, and effective mental health services are to reach a broader swath of American Indians who contend with mental health problems.

Keywords: American Indians, mental health services, historical trauma, traditional healing, Indigenous knowledges

American Indians are the contemporary descendants of Indigenous peoples who lived and thrived in the lands and territories now demarcated as the United States before the arrival of Europeans.¹ Demographers have estimated that this pre-Columbian population numbered at least 5 million inhabitants (Thornton, 1987). Beginning in the late 15th century, European exploration and settlement of North America led to dramatic—and frequently catastrophic—changes for American Indian communities, as contact and

subsequent interaction initiated epidemic disease, horrific violence, wanton exploitation, and incessant dispossession. This history of colonization has ensured that most modern American Indian communities contend with entrenched legacies of poverty, marginality, and disadvantage. Today nearly seven million people in the United States identify as American Indian or Alaska Native, including perhaps as many as four million members (i.e., citizens) of more than 570 federally recognized Tribal Nations (U.S. Census Bureau, 2020). These polities continue to exercise (limited) powers of sovereignty and self-governance across more than 300 reservations throughout “Indian Country.” The majority of tribal members reside away from tribal territories, and yet many maintain close kinship ties and cultural

Joseph P. Gone <https://orcid.org/0000-0002-0572-1179>

I am grateful to Carter Roeber and Ryan Brown for feedback in response to a draft of this article. All opinions expressed are those of the author.

Correspondence concerning this article should be addressed to Joseph P. Gone, Department of Anthropology, Harvard University, Tozzer Anthropology Building, 21 Divinity Avenue, Cambridge, MA 02138, United States. Email: jgone@g.harvard.edu

¹ Although it is customary to refer to American Indian and Alaska Native populations in combination, this article is most directly concerned with research and experience in American Indian communities in the contiguous United States.



Joseph P. Gone

affiliations with reservation-based populations. Still, even for urban American Indian communities, poverty, discrimination, and other associated adversities remain all-too familiar.

Although rigorous epidemiology is difficult to conduct in these communities, it is commonly observed that American Indians experience an array of health inequities, including disproportionately high rates of cancer, diabetes, heart disease, hepatitis, and obesity (Office of Minority Health, n.d.). Additional evidence attests to persistent mental health disparities in American Indian communities, especially in the domains of psychological trauma, posttraumatic stress, substance use disorders, and suicide (Beals et al., 2005; Gone & Trimble, 2012; Walls et al., 2020). Due to a history of treaties between Tribal Nations and the United States, it is an obligation of the federal government to provide health care for recognized tribal communities. It does so through the federal Indian Health Service (IHS), which funds (and, in many cases, administers) health services through hospitals, clinics, and stations on reservations for tribal members. The IHS also (partially) funds over 30 urban Indian health programs in major metropolitan areas with large numbers of off-reservation tribal members. As a health care system, however, the IHS is deeply underfunded, restricting American Indian access to care. Despite these funding constraints, nearly all IHS-funded health facilities include behavioral health (i.e., mental health and addiction treatment) services (IHS, 2011). Nevertheless, specialty mental health providers—especially psychiatrists and psychologists—remain in short supply. Counseling is primarily offered by social workers, and medications are often prescribed by non-psychiatric physicians.

By way of brief self-location, I am an enrolled member of the *Aaniiih*-Gros Ventre Tribal Nation of the Fort Belknap Indian Community in north-central Montana. Although born and reared in Montana, I did not return to the reservation until my college years more than three decades ago. Since then, I have endeavored to explore and explicate American Indian mental health needs and concerns through research partnerships and collaborations in eight different Indigenous communities (including one Canadian First Nation). In this article, I will recount an early career lesson from a research project on my own reservation that first alerted me to key sensitivities and sensibilities surrounding “mental health” among some American Indian people. As I will explain, this project yielded an alternative (or alter-Native) Indigenous explanatory model for conceptualizing depression and problem drinking in (post)colonial context (acknowledging that the *post* in postcolonial is debatable in the U.S. context). Based on this suggestive formulation, I will then unpack an alter-Native framework for mental health concerns that has emerged through my subsequent research partnerships. Specifically, this Indigenous parapsychiatric framework parallels reigning professional discourse concerning four relevant domains: distress, well-being, treatment, and evaluation. For each of these domains, American Indian community mental health advocates recognize and promote ideas and understandings that reframe and contest professional mental health assumptions and commitments in striking ways.

An Early Career Lesson

As I embarked on my research career, I grappled with the problem of American Indian mental health inequities. As I have noted, too many of our reservation communities contend with epidemic levels of trauma, substance abuse, and suicide. At the same time, the community mental health services that are supported by the IHS are deeply underfunded. This unfortunate situation results in a large unmet need with respect to mental health concerns. Thus, in attempting to remedy these community inequities, juxtaposition of pronounced mental health problems with underfunded mental health services suggests an ameliorative course of action: allocate additional funding to expand community mental health services (e.g., build more clinics, hire more providers). And yet, one of my earliest research projects complicated this conclusion.

An Ethnographic Interview

In June of 1999, I returned to *Aaniiih* tribal territory on the Fort Belknap reservation to explore in open-ended and discovery-oriented fashion how other tribal members conceived and conveyed the relationships between culture, clinical depression, and alcohol dependence. My goal was to “bracket” (i.e., hold at bay, to the degree possible) my own

professional orientation and training in clinical psychology and instead to privilege and prioritize local conceptions of these mental health concerns among several members of a large extended family on the reservation. During my 2-week visit, I conducted formal ethnographic interviews with four individuals about these matters. I later returned in the summer of 2001 to continue this inquiry, but from all of these consultations one interview stood out.

Specifically, I drew an important lesson from a middle-aged, self-identified “traditionalist,” who himself had never pursued or received any kind of mental health services. Rather, as a practitioner of Indigenous spirituality (and a critic of Christianity), Traveling-Thunder—the Indian name he elected to go by in our work together—discussed these mental health concerns from an entirely different frame of reference. Moreover, his reflections on the relationships between culture, depression, and problem drinking were so clear and coherent that they represented an *explanatory model* of illness (Weiss & Somma, 2007). Briefly, an explanatory model is a formulation of illness concerning any of five domains: etiology, symptomology, pathophysiology, course, and treatment. The concept was developed to afford cross-cultural consideration of illness experience in clinical encounters, in which the diverse explanatory models of patients, family members, and clinicians may not align (Kleinman, 1978).

I have explicated Traveling-Thunder’s explanatory model in greater detail elsewhere (Gone, 2007, 2008b, 2019, 2021). In this article, I selectively excerpt from this interview to summarize a key insight about American Indian community mental health services. With respect to my queries, Traveling-Thunder offered an account of the origins of mental health problems in our community that depended on his identification of four historical eras that have impacted American Indian lives. Based on his descriptions of these eras, I labeled these as: paradise, conquest, loss, and revitalization. Moreover, contained within this historical account, Traveling-Thunder also charted an explicit sequence of impacts that might culminate in mental health crisis for American Indians. Finally, based on this formulation, Traveling-Thunder reflected on the possibilities for therapeutic benefit and recovery in illuminating fashion.

An Explanatory Model

The first historical era described by Traveling-Thunder, *paradise*, refers to a time of precolonial existence for American Indian peoples: “See there was no alcohol in this continent 500 years ago. There were no drugs. There were no problems. No domestic problems. No social problems.” He went on to explain why this way of life was free of “social problems”: “Everything was good because everybody lived according to custom and teachings. And there were no jails, no hospitals. There were no prisons, no insane asylums.

There was none of that stuff because everybody lived according to a strict custom.” Thus, for Traveling-Thunder, American Indians enjoyed an idyllic life before colonial contact due to the strict observation of Indigenous “custom and teachings.” Unfortunately, strict adherence to these customs and teachings would soon be disrupted.

The second historical era described by Traveling-Thunder, *conquest*, refers to a time of colonial contact between American Indians and European settlers: “But when the Whiteman came, they . . . forced the . . . Indian people to get rid of . . . religious spiritual beliefs. They forced them to trade their economy, which was based on the barter system and on living off of the land.” Note here that American Indian “religious spiritual beliefs” were the first casualty of Euro American subjugation. “Then they turned around and forced their culture on them—their religion, their beliefs, their foreign ways onto them—by taking all the young people out of the homes and putting them away in boarding schools.” Here Traveling-Thunder referred to the coercive policy of mandatory assimilative education of American Indian children in government-funded industrial schools. With reference, then, to this orchestrated annihilation of Indigenous custom, Traveling-Thunder simply declared, “It’s genocide.”

The third historical era described by Traveling-Thunder, *loss*, refers to a time of postcolonial effects among subjugated American Indian peoples: “If you don’t know your own true oral history, your true oral traditions and customs, . . . where you come from, and what’s supposed to be important to you, well, you’re gonna feel empty. You’re gonna feel like you don’t belong.” He elaborated further: “Because we don’t fit in with the Whiteman’s system. We never did and we never will.” He directly linked these experiences to substance abuse: “It basically boils down to pride. If people ain’t proud of who they are, where they come from, and what they’re doing, then they’re gonna . . . be doing these things: alcohol, drugs.” Worse things might follow: “And once you’re into alcohol and drugs . . . you’re gonna probably get into a depression . . . and you’re gonna . . . not feel worthy of being a human being and you’re gonna want to kill yourself.” Thus, among the consequential effects of colonial subjugation, Traveling-Thunder identified the “Whiteman system” as pathogenic, with accompanying anomie precipitating mental health crisis.

The final historical era described by Traveling-Thunder, *revitalization*, refers to the possibilities for postcolonial remedy in American Indian communities: “After we looked around and realized that . . . we left something behind . . . , we started going back to the hills to fast. . . . We started going to the sweat lodges to pray We started going to the elders to learn.” Here Traveling-Thunder was referring to the Indigenous spiritual reawakening that occurred during the Red Power movement of the 1970s. “I would give the credit to the Creator, and to the spirit world, for pitying

the people to allow us to get [our sacred traditions] back.” He explained the relevance of these sacred traditions: “To me what that ceremony does is . . . you’re calling on the Creator, the spirit world . . . for life, or for good health, or for a . . . good clean mind. An alcohol and drug free mind. . . Or for survival even. Even survival.” Thus, for Traveling-Thunder, it is the American Indian return to the observance of sacred customs and teachings that can put the world right once more. In this sense, history in Traveling-Thunder’s account was cyclical.

Abstracting from these interview responses, the explanatory model of depression, problem drinking, and mental health crisis expressed by Traveling-Thunder contains several noteworthy features. First, it included a clearly specified pathological process, in which colonial subjugation includes cultural repression (i.e., “forced . . . to get rid of their way”) that, in turn, produces an overwhelming disorientation wrought by pervasive social disruption (i.e., not knowing “where you come from, and what’s supposed to be important to you,” including loss of pride). The resultant anomie (or normlessness) gives rise to (in this specific order, according to Traveling-Thunder): substance abuse, depression, worthlessness, and suicide. In his account, Traveling-Thunder offered minimal elaboration of personal distress at an individual level of analysis. Moreover, his account was neither biological (e.g., he did not mention genetic predispositions or brain chemistry) nor especially psychological (e.g., he did not mention psychic trauma or family dynamics), but rather steeped in history, culture, and spirituality.

Most important, Traveling-Thunder identified Euro American colonization of American Indians as the originating cause of community mental health concerns, underscoring the pathogenic features of structural racism as established in the “Whiteman system” (as expressed through sequential policies of land dispossession, economic exploitation, coercive assimilation, and so forth). In so doing, he clearly emphasized systemic factors over intrapersonal factors in accounting for mental health problems, upending reigning professional preferences for person-centered biases in causal attributions for social problems (Caplan & Nelson, 1973). In summary, he avoided “victim blame.” Beyond this, Traveling-Thunder described collective community vulnerabilities to these outcomes, generalizing his responses to all American Indians rather than to this or that tribal community (or to this or that demographic group within a tribal community). As I will discuss later, this explanatory model was an early instance of the now widespread concept of Indigenous historical trauma.

An Ideological Endeavor

With respect to this explanatory model, I wondered about the relevance of mental health treatments and services. I

asked Traveling-Thunder about the conditions under which he might refer a loved one for existing mental health treatments at the IHS behavioral health clinic on the reservation for help. He considered my question soberly before responding: “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 . . . shrewder way than the old style of bullets.” This reference to warfare surprised me. “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.” What choice? “[If you] want to [look] good to the Whiteman, then . . . go [to the] White psychiatrists . . . and say, . . . ‘Go ahead and rid me of my history, my past, and brainwash me forever so I can be like a Whiteman.’” Traveling-Thunder left little doubt that this was a choice that he himself was not inclined to make.

In these words, Traveling-Thunder declared professional mental health services—as provided by “White psychiatrists” to American Indians through an IHS clinic—to be an ideologically suspect endeavor. Specifically, he linked these services to ongoing warfare against American Indian people for which the stakes are not merely lands and lives, but souls (after Foucault) in which the past, present, and future—the very continuity that comprises identity—are at risk due to “brainwashing.” Thus, for Traveling-Thunder, mental health services harbor the potential to enact neo-colonial cultural proselytization. Such proselytization reflects an exercise of power through modern political technologies originating from the behavioral and clinical sciences (i.e., psychotherapy) that subjugate not one’s physical body but rather one’s interior life (i.e., psyche or soul; Foucault, 1979). Indeed, it is this modern intersection of power, technology, and interiority that has advanced new regimes of socialization into self-regulation that is properly conceived of as “subjectivity” (i.e., subjects who have been subjugated to regimes of societal power).

And so, to return to the challenge of American Indian mental health inequities, the dilemma of disproportionately high community distress and underfunded community services may not in fact be resolved by simple expansion of available mental health providers and treatments. Instead, Traveling-Thunder alerted the profession to the twin problems of cultural difference and of cultural dominance. The problem of cultural difference arises from the fact that European settlers and American Indian people hail from historically distinctive cultural settings. Thus, diverse cultural assumptions, orientations, and practices associated with divergent cosmologies (which themselves can underlie patterns and preferences with respect to sociality and selfhood) persist in contemporary life in the United States. In consequence, the norms, routines, and logics of the workaday mental health clinic are not those

of the tribal community (and not even those of many other communities, except perhaps in the upper-middle class suburbs).

Of course, cultural differences are not uncommon and can be routinely negotiated when parties come together to do so on an even playing field. But American Indian communities struggle to find equal footing with many Euro Americans due to a long history of cultural domination by invading settlers. The problem of cultural dominance arises from the fact that newly arrived Europeans subjugated American Indian peoples in almost every domain of life. Indeed, even the specialized educational system designed for American Indian children operated under the slogan, “Kill the Indian, Save the Man” (Pratt, 1973). In summary, colonial violence was directed toward dispossession and control of American Indians, and this legacy of colonization includes the orchestration of societal structures that ensure disparities in wealth, resources, visibility, power, and access to equal opportunity. These asymmetries persist today and continue to manifest through health and mental health disparities.

A (Post)Colonial Predicament

Traveling-Thunder’s critique of community mental health services for American Indians led me early in my career to identify a (post)colonial predicament that confronts psychologists and other helping professionals. On one hand, these communities too often comprise impoverished high-risk settings and thereby exhibit urgent mental health needs, as attested to by generations of mental health researchers (for a review, see [Gone & Trimble, 2012](#)). On the other hand, the (underfunded) professional mental health services that are provided by the federal government in fulfillment of U.S. treaty obligations are incongruent with the orientations, dispositions, and desires of a key (traditionally aligned) constituency within these populations. This constituency may well concur with Traveling-Thunder that participation in these services constitutes an open invitation to “brainwash me forever so I can be like a Whiteman.” Perhaps this explains why some American Indians (e.g., 48.9% of those with depression or anxiety on one reservation) are more likely to consult traditional healers than mental health professionals ([Beals et al., 2005](#)) or prefer informal traditional services to formal medical services for their mental health concerns ([Walls et al., 2006](#)).

A chief implication of the (post)colonial predicament is that “mental health” services for American Indian peoples may require substantial reform if all members of these communities are to secure fully accessible, culturally appropriate, and demonstrably effective helping interventions in times of disabling distress ([Gone, 2008a](#)). Specifically, American Indian communities may well benefit from unprecedented innovations in psychosocial helping services

that have yet to be fully explored, implemented, and evaluated. How then might mental health advocates, professionals, and researchers with a stake in contemporary American Indian well-being proceed to formulate, evaluate, and establish alternative, locally grounded, and culturally resonant professional services? I propose that such service innovations will necessarily require collaborative partnerships with American Indian community members for program development in which local authorities contribute expertise based on Indigenous knowledges and therapeutic traditions (for program examples, see [Gone & Calf Looking, 2011, 2015](#); [Gone et al., 2020](#)).

An Alter-Native Psy-Ence

I interviewed Traveling-Thunder more than two decades ago, but his explanatory model accounting for the links between American Indian culture, depression, and problem drinking—and the (post)colonial predicament that it revealed—has profoundly shaped my scholarly inquiry ever since. In subsequent research partnerships with several tribal communities, I have come to recognize related American Indian concerns and critiques about mental health services ([Gone, 2008a](#)). In fact, Traveling-Thunder’s explanatory model for mental health concerns emerged as just one facet of a more comprehensive American Indian framework that can be seen as parallel to but distinct from professional discourse ([Gone, 2009](#); [Gone & Trimble, 2012](#)). Like Traveling-Thunder’s assessment of mental health services, these alter-Native interpretations, explanations, and expectations of the professional endeavor are attentive to the problems of cultural difference and of cultural dominance. Thus, in robust (post) colonial fashion, these alter-Native perspectives call into question the authority of professional knowledge, the promise of therapeutic benefit, and the conventions of service delivery. Professional attention to these perspectives may encourage greater reflexivity, relevance, and regard.

In this article, I adopt the term *psy-ence* to refer to this corpus of professional expertise, as this calls attention to the historically contingent nature of knowledge that has emerged from psychology, psychiatry, psychoanalysis, and psychotherapy (or the *psy-* disciplines) even as it remains critically attuned to the dynamics of power and ideology expressed through such knowledge (ala Foucault; see [Rimke & Brock, 2012](#)). [Gone and Trimble \(2012\)](#) first introduced this alter-Native *psy-ence*, but the scope and scale of this Indigenous para-psychiatric framework is worthy of more complete conceptual synthesis (even if no single interlocutor of mine ever set forth this para-psychiatric framework in overt and comprehensive fashion). In the remainder of this article, I review and describe American Indian perspectives on four domains that are familiar to mental health professionals—distress, well-being, treatment, and evaluation—that have been evident everywhere I

travel in Native North America. Of note, these perspectives frequently contest and recast key concepts and conventions that have oriented and organized the activities of professional psychologists and other mental health providers.

Distress: From Mental Disorder to Historical Trauma

A key domain that structures expert discourse in the mental health professions is the nature of the distress to be remedied. By convention in the United States, mental health professionals—including health service psychologists—diagnose and treat distress as classified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013)*. The current fifth edition of the *DSM* defines “mental disorder” as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (p. 20). It classifies more than 150 disorders (e.g., Alcohol Use Disorder) in nearly 20 categories (e.g., Substance-Related and Addictive Disorders). The overarching problem frame of the *DSM* is medical, enabling clinicians to diagnose syndromes, formulate cases, recommend treatments, and obtain reimbursement for their services from the health care system.

As a medical classification, then, the *DSM* focuses on disorders that afflict individual patients. Two implications are noteworthy. First, diagnosis centers on the dysfunctions and deficits of the person rather than on the adversities, inequities, and disadvantages that characterize that patient’s social context. Second, diagnosis is based on application of standardized criteria that facilitate diagnostic agreement between clinicians by limiting attention to personal and cultural meaning-making. Thus, based on revisions that appeared in *DSM-5*, a patient can be diagnosed with Major Depressive Disorder even if she is grieving the sudden death of a loved one (i.e., ignoring important facets of the social context), but cannot be diagnosed with posttraumatic stress disorder (PTSD) for this same loss unless the death was accidental or violent (i.e., ignoring the constitutive role of meaning-making for psychological trauma). Note that the opposite was true for diagnosing these disorders in *DSM-IV* (Langa & Gone, 2020).

Although critiques of the *DSM* classification are commonplace, from an Indigenous perspective the *DSM* is challenging to apply for other reasons. For example, it can be difficult to discern whether disparities in diagnostic prevalence in American Indian communities (e.g., low rates of internalizing disorders; Walls et al., 2020) are in fact accurate or instead artefactual. Moreover, the *DSM* is selectively incomplete with respect to (post)colonial populations by including no disorders of rage or identity. But these are trifles compared with the overarching desire to “resocialize”

mental health problems in terms of surrounding historical and societal context (Kirmayer & Gold, 2012). The primary way that American Indian communities attempt this with respect to identifying the dis-order to be remedied is through adoption and promotion of the concept of *historical trauma* (HT; Brave Heart, 2000; for recent reviews, see Gone et al., 2019; Hartmann et al., 2019).

Briefly, Brave Heart—a Lakota social work researcher—encountered the concept of HT during her clinical training, in which her supervisors adopted the term to discuss the problems of children of Jewish Holocaust survivors (Brave Heart & DeBruyn, 1998). She subsequently applied the concept to the experiences of her own people, who survived the Wounded Knee massacre of 1890 (Brave Heart, 2000). As its Indigenous scholarly advocates have characterized it, HT can be understood as a synthesis of two familiar concepts: historical oppression and psychological trauma. It bears a resemblance to PTSD, but what is said to distinguish HT from personal trauma is what Hartmann and Gone (2014) summarized as the Four Cs of HT: it originates in *colonial encounters*, it is *collectively experienced* by groups of people, it is *cumulatively escalating* across successive waves of adversity, and it is *cross-generationally transmitted* from ancestors to descendants.

Thus, HT functions to trace the legacy and impact of ancestral suffering on current generations of American Indian people. In so doing, HT affords a sociohistorical explanation for mental health disparities, reframes mental health problems as (post)colonial pathologies, resolves paralyzing self-blame by linking suffering to shared community experiences, and legitimates Indigenous therapeutic practices as one source of potential remedy (Gone, 2013). Although HT is often invoked within a health or medicalizing frame (Hartmann et al., 2019), there can be no doubt that it aims to socialize and contextualize health disparities well outside of an individualist and deficit-oriented clinical discourse. Moreover, HT has circulated widely throughout Indian Country and has become the preferred problem frame for American Indian health disparities. Finally, HT bears a strong resemblance to the explanatory model expressed by Traveling-Thunder, although it differs in one important respect: Traveling-Thunder never mentioned psychological trauma and in general provided a notably a-psychological account.

Well-Being: From Neo-Liberal Individualism to Indigenous Relational Selfhood

Another key domain that structures expert discourse in the mental health professions is the formulation of robust mental health and optimal well-being. These assumptions frequently remain tacit, as the primary goal of providers is to assess and treat client distress or impairment in the effort to reduce symptoms and improve functioning. And yet, any

therapeutic endeavor necessarily depends on expectations and understandings of some ideal that restorative efforts aim to achieve. These ideals are historically contingent and culturally constituted, which is to say that human modes of life have varied in striking ways across time and place. In charting the rise of modern identities, for example, Taylor (1989) traced three major enduring features from historical “sources of the self”: reflexive inwardness (based in Augustinian theism as refracted through Descartes and Locke), disengaged reason (based in naturalism as advanced through the scientific revolution), and Romanticist expressivity (based on Hume’s moral sentiments as rearticulated by Rousseau). For Taylor, even though some consensus is afforded by Judeo-Christian tradition, modern identities express these competing moral frameworks, leading to social conflict even as most people embrace and enact tenets of each (often in contradictory fashion).

In psychology, Cushman (1990) explored *historical contingency* by charting the rise of the “empty self” following World War Two, which could only be “filled” through eating, shopping, and emulating celebrities. According to Cushman, the postulated remedies for the empty self—advertising and psychotherapy—are in fact complicit by promoting “lifestyle solutions” rather than reclaiming lost community and tradition. In parallel fashion, Markus and Kitayama (1991) explored *cultural constitution* by reviewing two primary forms of divergent self-orientation. They noted the distinctive cross-cultural implications of autonomous independence versus harmonious interdependence for cognition, emotion, and motivation. Kirmayer (2007) reconstructed the ideals presumed by psychotherapy as identifiably Western. Specifically, he noted that psychotherapeutic practice often depends on a form of selfhood that is agentic, rationalistic, monological, and univocal, and a form of personhood that is individualist, egocentric, and psychologically minded (or “psychocentric”; see Rimke & Brock, 2012). By extension, Furedi (2004) explicated “therapy culture” to observe that everyday life has been colonized by pop-psych sensibilities such as the fragility of the self and the pursuit of individual fulfillment in ways that exacerbate isolation and dependence rather than remedying these ills.

With respect to (post)colonial populations, Adams et al. (2015) issued a call to “decolonize” psychological science. In their critique, they decried the reigning form of “neoliberal individualism”—in which “free agents” navigate “free markets” in autonomous pursuit of wealth and happiness—and insisted instead that psychology must “consider the extent to which conventional scientific wisdom and professional practice reflect and reproduce ideologies of neoliberal individualism and its associated violence” (p. 220). Although American Indian communities exist within this dominant neoliberal order, the activities, orientations, and concerns that preoccupy our communities diverge in substantial ways. Chief among these is that American Indian

life is typically structured by extensive kinship roles and obligations within extended family networks. This leads to observable everyday practices such as addressing others by their kinship terms (e.g., “auntie,” “brother”) rather than by their personal names. In fact, in some Inuit communities, newborns were named after recently deceased individuals to herald the return of the deceased; thereafter, such newborns assumed the kinship relations of their namesakes, addressing much older persons as a daughter or husband, for example (Nuttall, 1994).

At the same time, most American Indian peoples are careful to recognize and protect the individual autonomy of other persons (both human and nonhuman). Among the Plains Cree, Darnell (1991) noted two metaphors that captured this regard for autonomous personhood: circles that touch at their perimeters but do not overlap, and stars that pass each other in the night sky, exerting joint influence without contact. In practice, she observed that Plains Cree individuals normatively refrain from speaking for others, asking direct questions of others, attributing motives (in unqualified fashion) to others, and making blatant claims on others. These interactional preferences are often identified in American Indian communities as an ethos of indirection and noninterference that safeguards personal autonomy. Thus, many contemporary American Indian communities exhibit two sets of commitments: the roles and duties associated with interdependent self-orientations as well as the autonomy and freedom associated with independent self-orientations. Perhaps this is best characterized as *self-determination in caring for others*. Moreover, this social orientation extends to caring for nonhuman relatives, whether animals, plants, and other spirit beings that humans depend on for health, help, and long life.

Thus, robust mental health and optimal well-being in American Indian communities frequently entail expansive forms of self-in-relation. Quotidian kinship practices surrounding naming and addressing others marks and extends personal identity beyond the individual. Besides identity, community socialization into these expansive forms of relationality configures emotional experience and expression, leading to the salience of various social emotions, such as compassion (or “pity”), respect, loneliness, resentment, jealousy, pouting, hostility, suspicion, and, of course, love. In consequence, dysfunction in American Indian communities can retain this expansive relational cast (e.g., “insane jealousy,” depressive loneliness; see O’Neill, 1998). Mind and mentality in American Indian communities has also been described as extending beyond the individual to others (Farnell, 1995) and to “the greater harmonious mind of the entire creation” (Junker, 2003, p. 188). Indeed, American Indian populations are highly spiritual or religious. Given that only 3–11% of two large reservation populations reported no religious participation (Garrouette et al., 2014), it seems safe to conclude that Indigenous relational selfhood

extends well beyond humans to other orders of being in the cosmos.

Treatment: From Evidence-Based Practice to Indigenous Traditional Healing

A third key domain that structures expert discourse in the mental health professions is the development and delivery of treatments that can remedy (or reduce) distress, dysfunction, and impairment. Psychiatrists (and some psychologists) prescribe psychopharmacological treatments, but the majority of mental health professionals provide psychosocial treatments in the form of counseling and psychotherapy. With respect to the treatment of mental health problems, these professionals have been increasingly obliged to adopt forms of evidence-based practice (EBP). In psychology, EBP has been defined as the “integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Thus, EBP has been conceived as a three-legged stool that metaphorically stands on (1) the best available research evidence, (2) clinical expertise, and (3) client preferences and values (Lilienfeld et al., 2013). It seems self-evident why EBP should depend on clinician proficiency with, and client openness to, a given treatment, but whether a particular treatment has amassed adequate research evidence to be considered evidence-based—and how providers ought to evaluate such evidence—is a professionally contentious issue.

For example, drawing on the APA Task Force’s (2006) definition of EBP, some psychologists contend that professional recognition of “patient characteristics, culture, and preferences” affords expansive license to provide or promote interventions with minimal outcome evidence concerning treatment efficacy or clinical utility. With respect to the three-legged stool metaphor of EBP, however, Lilienfeld and colleagues (Lilienfeld et al., 2013) countered that “scientific evidence must be accorded priority above the other two legs of the stool” (p. 886). This construal—that conceives of EBP as an approach to clinical decision-making that emphasizes the scientific evaluation of research evidence—aims to address several interrelated concerns. These include: the need for mental health treatment frequently eclipses available services (Mental Health America, 2020), many mental health treatment approaches have not been rigorously evaluated, clinicians usually believe that their preferred treatments work best, clinician beliefs in their own efficacy can be mistaken, and some treatments have been shown to cause harm (Lilienfeld, 2007). With respect to professional avoidance of harmful treatment, for example, critics point to the proliferation in the 1990s of facilitated communication for autism or recovery of repressed memories. In short, mandates for EBP in mental health services

aspire to ensure that professionals act on “credentialed knowledge” (Meehl, 1997).

At least in the context of a “therapeutic triad” in which *credentialed clinicians* provide *costly services* to *vulnerable patients* (Gone & Alcántara, 2007), professional accountability seems paramount. But consensus about the kinds and quality of research evidence that are considered necessary for undergirding legitimate professional practice in psychology remains elusive, and EBP in the mental health professions has occasioned numerous and wide-ranging critiques (e.g., Tanenbaum, 2005). These debates concerning professional accountability illuminate longstanding tensions between clinical scientists and professional practitioners. Kazdin (2008) sought to repair this research-practice divide by recommending a refocus on patient care through analysis of mechanisms of therapeutic change, identification of moderators of change that translate to clinical practice, and exploration of patient experiences through qualitative inquiry. These general recommendations do not always satisfy multicultural professional psychologists, who view the promotion of an efficacy-centered, technique-driven EBP as at best scientifically premature and at worst culturally harmful for ethnic and racialized populations in the United States (Gone, 2008a; Hall, 2001; Wendt et al., 2015). Although some have proposed the concurrent pursuit of both EBP and cultural competence (Castro et al., 2010; Whaley & Davis, 2007), American Indian community advocates are more likely to resist the promotion of EBP in mental health.

Indeed, Gone and Calf Looking (2011) considered a common claim encountered in these settings: “our culture is our treatment” (p. 293). Thus, rather than embracing or promoting EBP, this alter-Native culture-as-treatment claim instead positions American Indian cultural practices and ceremonial traditions as therapeutic in their own right and on their own terms. For example, in my interview with Traveling-Thunder (Gone, 2008b), I asked what alternative he would pursue instead of IHS mental health services for loved ones contending with marked distress: “Well, you would probably . . . put up a ceremony and pray for them. There’s always a spiritual connection that can help them.” He further explained that “You pray from the heart. . . . If you put up the ceremony good, then the Spirits look at you and they say, ‘Well, this guy really means it. Let’s help him.’” In turn, the Spirits might respond: “They say there’s a 50/50 chance that you could get help for that person you’re praying for. . . .which would be a lot better help than locking them away in [the State Mental Hospital].” In this response, Traveling-Thunder revealed the therapeutic rationale of the culture-as-treatment claim, namely that salutary benefit arises from a “spiritual connection” in which sincere petition to powerful nonhuman persons can yield help for those in crisis or distress.

American Indian commitments to the centrality of spiritual and ceremonial practices for therapeutic activities are

readily evident throughout Indian Country, emerging when these communities first began to incorporate sweat lodge ceremonies into their addiction treatment programs in the 1980s following administrative transfer of these services to Tribal Nations (Hall, 1985). Since then, Indigenous traditional healing has been widely recovered and reclaimed (Redvers & Blondin, 2020). Traditional healing is typically a religious endeavor in which ritual leaders ceremonially interact with powerful nonhumans who circulate blessings and life. Both the nature of healing power and community protection of these traditions entail secrecy, but analysis of publicized historical accounts of traditional healing can be illuminating (Gone, 2010, 2016, 2021). In 2010, I convened a Gathering of American Indian Healers to consider collaborations between traditional healers, mental health professionals, and researchers to improve tribal helping services (Moorehead et al., 2015). More recently, in November of 2019, a small group of American Indian health scholars facilitated a Traditional Medicine Summit that convened 30 American Indian healers, providers, and researchers to discuss community-based integrative health services (Tribal Health Research Office, National Institutes of Health, n.d.).

Evaluation: From Scientific Outcome Assessment to Indigenous Ways of Knowing

A final key domain that structures expert discourse in the mental health professions is the logic of inquiry for evaluating “what treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?” (Paul, 1969, p. 44). In pursuit of intervention outcomes assessment, psychologists and other mental health professionals embrace and promote scientific evaluation of treatment effects. Defining science as a form of inquiry in ways that generalize across so many diverse scholarly disciplines (e.g., astronomy, paleontology) is challenging, but elsewhere I have observed that such inquiry frequently involves the precise measurement of phenomena by an interchangeable observer that is used to evaluate falsifiable explanations of such phenomena (Gone, 2011). As an Enlightenment project, science (in this sense) entailed a distinctive synthesis of rationalist and empiricist philosophical traditions that adopts a (selective) skepticism and presumes a mechanistic materialism to extend human rationality beyond the unaided powers of reason (i.e., as a cognitive prosthesis, of sorts).

In the assessment of treatment outcomes, scientific knowing usually entails experimental comparisons of treated and untreated patients, statistical analysis of relevant variables, circulation of findings for skeptical interrogation by peer scientists, publication of research in peer-reviewed outlets, and eventual acceptance of findings when replicated across multiple studies. Knowledge of treatment effects secured in this fashion is probabilistic, abstract, and general (i.e.,

nomothetic) rather than certain, concrete, and distinctive (i.e., idiographic), and there is no guarantee that the demonstrated benefits of scientifically evaluated interventions will necessarily apply in the case of this or that specific patient. Beyond this, there are numerous other complications. Scientific inquiry works better in theory than in practice. Scientific practice depends on assumptions that are underexamined or even ignored by scientists. Answers to crucial questions can be extremely elusive. When it comes to scientifically demonstrating the benefits of health interventions, many empirically supported treatments falter on replication (Ioannidis, 2005a); indeed, “most published research findings are false” (Ioannidis, 2005b).

Nevertheless, despite these limitations, scientific outcome assessment of mental health treatments is widely deemed as the preferred way to bolster confidence in intervention effectiveness. And yet, Lilienfeld and colleagues (Lilienfeld et al., 2013) reviewed six sources of resistance (e.g., spurious therapeutic effectiveness, nomothetic-idiographic disjuncture, and statistical complexity) to account for the dismissal of outcome evidence by many mental health professionals. As I have already noted, American Indian advocates and professionals also ignore or resist scientific findings surrounding treatment effectiveness. With respect to treatment evaluation proper, scientific outcome assessment has attracted minimal interest in American Indian communities. For example, in a 2004 ethnographic investigation of therapeutic practice in a Canadian First Nations community treatment center, I discovered that counselors and administrators were attracted to treatment approaches based on their spiritual qualities. They exhibited little awareness of or interest in scientifically vetted interventions (Gone, 2009).

One indicator of the alter-*Native* grounds for assessing intervention effectiveness was apparent during my consultation with the Blackfeet Nation’s addiction treatment program (Gone & Calf Looking, 2011, 2015). In 2009, the program’s cultural counselor and I approached the leadership of the traditionalist Crazy Dog Society to solicit their help in designing addiction treatment that would center Blackfeet therapeutic traditions. During a ceremonial gathering of the society, I conveyed our interest in rethinking addiction treatment on the reservation and included our plan to evaluate the newly designed approach. I stressed the importance of formal evaluation because mental health researchers did not yet know whether American Indian participation in traditional cultural and ceremonial practices could effectively treat addiction. At this, the gathering erupted into raucous laughter. The ceremonial leader then patiently explained that every participant in the ceremony was living proof that cultural traditions could remedy substance abuse problems. In this, he invoked the authority of firsthand experience (Gone, 2012).

American Indian scholars have increasingly described, adopted, and refined Indigenous ways of knowing for academic knowledge production. Castellano (2000) explained that Indigenous knowledge traditions depended on three sources: traditional teachings (e.g., tribal myths, practical know-how), empirical knowledge (e.g., medicinal plants, animal migration patterns), and revealed knowledge (e.g., spiritual communications through dreams and visions). Moreover, these knowledges can be characterized (using the mnemonic of HOPES) as: holistic, oral, personal, experiential, and storied. These attributes stand in marked contrast to the epistemological qualities of scientific inquiry (e.g., abstract, general) already described. Indeed, based on her consultations with Cree interlocutors, Darnell (1991) explained that “eye-witness accounts based on personal experience are privileged over the theoretical, abstract, and second-hand” (p. 95). Thus, there may be no higher authority within Indigenous ways of knowing than firsthand personal experience. Perhaps this accounts for American Indian assertions that, in contrast to EBP, we should instead promote “practice-based evidence” (Echo-Hawk, 2011).

Conclusion

In this article, I have recounted an early career lesson that defined a (post)colonial predicament for mental health professionals seeking to provide community mental health services for American Indians. Specifically, a middle-aged reservation traditionalist conveyed an explanatory model of illness that framed clinical depression and problem drinking as originating in Euro American colonial subjugation that disrupted everyday Indigenous observance of distinctive “customs and teachings.” This orchestrated assault on Indigenous ways of life gave rise to community anomie, substance abuse, depression, worthlessness, and suicide. According to Traveling-Thunder, “White psychiatrists” at the IHS clinic would only make matters worse by “brainwashing” American Indians who seek help. Thus, at least for some traditionally oriented American Indians, the helping services on offer are incommensurate with community mental health needs, creating a (post)colonial predicament. Although his explanatory model was minimally psychological, Traveling-Thunder prefigured the rise of Indigenous historical trauma as an account for American Indian mental health inequities. Indeed, he invoked the contours of an alter-Native framework for mental health concerns that is parallel to but divergent from professional discourse.

This para-psychiatric framework encompasses four major domains in ways that reframe and contest the assumptions and commitments of mental health professionals in important respects. With respect to distress, American Indian communities emphasize historical trauma rather than mental disorders. With respect to well-being, American Indian communities emphasize

Indigenous relational selfhood rather than neo-liberal individualism. With respect to treatment, American Indian communities emphasize Indigenous traditional healing rather than EBP. And with respect to treatment evaluation, American Indian communities emphasize Indigenous ways of knowing rather than scientific outcome assessment. Although no single community consultant ever synthesized this alter-Native psyche in explicit and comprehensive fashion, its tenets are recognizable wherever I travel in Indian Country. Consideration by psychologists of this alter-Native psyche is important if relevant, accessible, and effective mental health services are to reach a broader swath of American Indians who contend with postcolonial pathologies. Moreover, serious consideration of this framework enables the discipline to grapple with the adverse legacies of power, subjugation, and oppression in expansive fashion as ethnic and racialized populations in the United States pursue more just futures in self-determined ways.

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Received April 18, 2021

Revision received June 20, 2021

Accepted June 21, 2021 ■