Cultural Diversity and Ethnic Minority Psychology
2007, Vol. 13, No. 4, 356–363

1099-9809/07/$12.00 DOI: 10.1037/1099-9809.13.4.356

Identifying Effective Mental Health Interventions for American Indians and Alaska Natives: A Review of the Literature

Joseph P. Gone and Carmela Alcántara
University of Michigan, Ann Arbor

The pursuit of evidence-based practice (EBP) within the mental health professions has contributed to efficacious clinical intervention for individuals struggling with mental health problems. Within the context of the EBP movement, this article reviews the treatment outcome literature for mental health interventions directed specifically toward American Indians and Alaska Natives experiencing psychological distress. Fifty-six articles and chapters pertaining to the treatment of Native Americans with mental health problems were identified, though the vast majority of these did not systematically assess outcomes of specified treatments for Native American clients under scientifically controlled conditions. Of just nine studies assessing intervention outcomes, only two were controlled studies with adequate sample sizes and interpretable results relative to the identification of EBP among American Indians and Alaska Natives. The advantages and limitations of EBP for treatment of Native American mental health problems are discussed.

Keywords: Native Americans, mental health interventions, evidence-based practice, treatment outcome studies

> 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] white 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."
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> —"Traveling Thunder" (cited in Gone, in press d, p. 11)

As many U. S. citizens well know, this nation's tiny but diverse population of American Indians and Alaska Natives has endured centuries of colonial peril. Indeed, historical encounters of Native peoples with European Americans in the United States all too frequently involved military conquest, reservation captivity, assimilation campaigns, resource theft, and numerous other dangers, both mortal and ideological. These experiences—some of which persist to this day—have collectively established and transformed the psychologies of contemporary tribal peoples, in many instances complicating, compromising, and confounding "mental health" in these communities (Gone, 2006a). For good reason, many contemporary tribal peoples remain suspicious of the ultimate relevance and utility of conventional psychological interventions proffered by European American mental health professionals (as evidenced in the opening quotation from one Native American Traditionalist from the first author's home reservation).

Although methodologically sophisticated research on the incidence and prevalence of psychiatric distress or mental disorder in "Indian country" has been difficult to come by (Gone, 2003; Manson & Altschul, 2004; U. S. Department of Health & Human Services, 2001), recent scientific surveillance attests to high levels of "frequent mental distress" reported by Native American respondents (Zahran et al., 2004). In addition, recent community-based epidemiological findings (Beals et al., 2005) attest to the elevated lifetime prevalence of alcohol dependence, drug dependence, and posttraumatic stress disorder (PTSD) within reservation populations. Additional evidence further attests to alarming rates of other kinds of psychological dysfunction within these communities, including mood disorders, pathological reactions to violence and trauma, and suicide (Alcántara & Gone, 2007; Indian Health Service, 2005; Olson & Wahab, 2006; Pole, Gone, & Kulkarni, in press; U. S. Congress, Office of Technology Assessment, 1990).

Inasmuch as it remains the Trust Responsibility of the U. S. Congress to provide health care services to citizens of federally recognized tribal nations (Gone, 2003, 2004b; Pevar, 2004), the identification of state-of-the-art psychological treatments for mental health problems in Indian country would seem crucial to ensuring that American Indians and Alaska Natives obtain reliably accessible and demonstrably effective therapeutic interventions in times of distress. Unfortunately, the identification of treatment outcome studies for mental health problems experienced by Native

Joseph P. Gone and Carmela Alcántara, Department of Psychology, University of Michigan at Ann Arbor.

Support for the development of this article was provided by the One Sky Center: The American Indian/Alaska Native National Resource Center for Substance Abuse, Oregon Health and Science University, Portland, Oregon (funded by the Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services).

An early version of this article may appear in a technical report summarizing the official proceedings of the 2004 Best Practices Meeting of the One Sky Center.

This article was submitted for peer-reviewed publication with the permission and encouragement of faculty colleagues and sponsors at the One Sky Center.

Correspondence concerning this article should be addressed to Joseph P. Gone, Department of Psychology, University of Michigan, 2239 East Hall, 530 Church Street, Ann Arbor, MI 48109-1043. E-mail: jgone@umich.edu

Americans is no simple endeavor. This article will canvass the scientific literature related to this effort, while simultaneously reviewing concepts and approaches that frame (and complicate) the worthy pursuit of evidence-based practice in Native American mental health service delivery. At the outset we should clarify, however, that this review will omit literature evaluating treatments that target substance abuse exclusively because these are typically segregated from mental health treatments in clinical practice and are already the subject of recent reviews (see Hawkins, Cummins, & Marlatt, 2004; Mail, & Shelton, 2002).

Overview of Evidence-Based Practice

Clinical psychologists, psychiatrists, social workers, and other allied mental health professionals are increasingly interested in incorporating "evidence-based practice" (or EBP) into their treatment of distressed clients (see McFall, 2000, for an exemplar from clinical psychology). Originating within professional medicine in the United Kingdom, EBP aspires to anchor clinical applications to the existing body of scientific evidence concerning therapeutic outcomes (Wampold & Bhati, 2004). For example, Division 12 (Society for Clinical Psychology) of the American Psychological Association (APA) convened a Task Force on the Promotion and Dissemination of Psychological Procedures, which released a report in 1995 identifying "empirically supported" treatments for a variety of psychological disorders. Identification of these treatments was based upon explicit evaluation criteria pertaining to the quality of the empirical outcome literature associated with a given intervention (Chambless et al., 1996). The most recently published catalog of such treatments listed 108 well-established or probably efficacious treatments for adult psychological disorders and 37 for childhood disorders, including, for example, Exposure and Response Prevention for Obsessive Compulsive Disorder or Interpersonal Therapy for Major Depressive Disorder (Chambless & Ollendick, 2001).

Not surprisingly, officially sanctioned lists that are developed and disseminated by professional organizations have engendered fierce controversy because many mental health practitioners have been accustomed to providing therapeutic services to their clients based not upon a body of scientific evidence in support of their particular approaches or techniques, but instead upon conventions derived from their professional training, theoretical orientation, accumulated experience, clinical intuition, and/or personal preference. Nevertheless, proponents of EBP offer a compelling rationale for considering scientific evidence as superior to these conventions. Note at the outset, however, that this rationale applies to professional interactions involving what we designate as the "therapeutic triad," in which credentialed clinicians provide costly services to vulnerable clients suffering from clinically significant psychological impairment or distress.

The therapeutic triad recognizes that clinicians are credentialed (usually through master's or doctoral level training in accredited programs, plus professional licensure in the state in which they practice) precisely because they provide professional services that presumably require expertise beyond the facility of the general public to evaluate independently. In such instances, the philosophy of "caveat emptor" is trumped by the quality control efforts of relevant civic and professional bodies. Furthermore, these expert professional services are understood to be relatively scarce and, therefore, costly. Indeed, the majority of individuals experiencing diagnosable psychological distress in their lifetimes do not obtain specialized mental health treatment for their problems (Kessler et al., 1994), owing in part to the limited availability and high cost of these services (U. S. Department of Health & Human Services, 2005). Finally, persons who obtain such services typically contend with rather serious psychological disruptions in their lives and livelihoods. If ever individuals are in need of quality control and assurance to inspire their trust, bolster their confidence, and protect their interests, it is in these particularly vulnerable moments when sometimes even life and liberty are at stake. Thus, in instances properly characterized by the therapeutic triad, the professional obligation to provide the most effective therapeutic services available would seem beyond controversy or dispute.

Nevertheless, controversy or dispute arises because clinicians (a) believe and often proclaim that their services are in fact the "most effective" among the available alternatives (otherwise, they would not recommend them), and (b) disagree not infrequently with their colleagues about the treatment of choice for various psychological conditions or disorders (again, often based upon their training, orientation, experience, intuition, and/or preference). Obviously, under such circumstances, some professionals—at least some of the time—are advancing erroneous claims on behalf of their preferred therapies, approaches, or interventions (for provocative reviews, see Dawes, 1994a; Garb, 1998; Lilienfeld, Lynn, & Lohr, 2003). The EBP movement within the mental health professions contends that identification of the most effective therapeutic services among the available alternatives should occur through consideration of the results of carefully controlled scientific experiments assessing the causal efficacy of proposed or purported mental health treatments. The need for these Randomized Clinical Trials (RCTs) is based on the premise that—owing to a formidable cadre of cognitive tendencies that routinely besiege human inference (Dawes, 1994b, 2001)—reliable attribution of cause and effect relationships, especially in the convoluted context of human behavior and interaction over time, is extremely difficult (if not altogether impossible) for people to render casually or "off the tops of our heads." That is, in any given clinical "case," there are just too many plausible competing explanations for the patient's recovery to afford clear and authoritative conclusions about the causal efficacy of the intervention relative to reliable outcome.

In sum, having embraced the epistemological advantages of RCTs, the EBP movement aspires to relocate professional practice from the domain of clinical convention to that of scientific evidence. Projects such as that undertaken by the Division 12 Task Force of the APA have specified evaluative criteria, reviewed the scientific literature, and published a list of empirically supported treatments for perusal and adoption by mental health professionals. Similar evidence-based "effective practices," "model programs," and mental health "treatment guidelines" have been published by other government and professional organizations as well. Nevertheless, questions regarding the portability (or "generalizability" or "external validity") of these interventions to workaday clinical settings have been raised (Garfield, 1996; Peterson, 1996), including their relevance for populations of color in the contemporary United States (Bernal & Scharron-Del-Rio, 2001; Coleman & Wampold, 2003; Hall, 2001).

Within the context of the EBP movement, the principal goal of this article is to review the Native-specific outcome literature for

mental health interventions targeting the more prevalent psychological disorders in Indian country (deliberately excluding substance abuse interventions for the reasons previously cited).

Method

In order to ensure a systematic and comprehensive review of this literature, we undertook a series of online searches within four computerized bibliographic databases encompassing English-language citations of scholarly publications in the mental health field: PsycINFO, PubMed, Social Work Abstracts, and the Social Sciences Citation Index. Accurate and comprehensive identification of the Native-specific literature concerning treatment outcomes was attained through use of the proxy descriptors "treatment," "prevention," and "intervention," since these terms were presumed to be inclusive of any associated descriptors used to catalog pertinent outcome studies. In addition, 13 descriptors of mental health problems were employed in the database searches based upon epidemiological and anecdotal evidence attesting to their prevalence in and relevance for Native American populations. More specifically, these problem descriptors included mental disorders, depression, anxiety, suicide, PTSD, emotional trauma, child abuse, sexual abuse, attention deficit hyperactivity disorder (ADHD), antisocial behavior, conduct disorder, juvenile delinquency, and "postcolonial stress disorder." Finally, "Native American"/"American Indian" and "Alaska Native" were the terms selected as ethnopolitical group identifiers designed to limit search results to the Native-specific literature—use of these identifiers varied depending upon the database in question (e.g., PsycINFO prescribed use of the first term rather than the second).

Our review of the literature thus involved 312 searches employing the aforementioned descriptors within the respective databases (Computerized Database [4] × Practice Descriptor [3] × Problem Descriptor [13] × Group identifier [2]). These results were further supplemented by a manual search of the "Health and Mental Health Treatment and Prevention" section of a published bibliography of psychological abstracts pertaining to Native Americans (Trimble & Bagwell, 1995). Not surprisingly, many of these searches returned identical citations, though they also yielded a large literature that was not directly concerned with treatment approaches or techniques for mental health problems as such, or their target population was not explicitly or intentionally Native Americans. Citations generated in this fashion were meticulously checked for relevance to the task of identifying published English-language articles or chapters pertaining to mental health interventions for Native Americans (with the adoption of liberal inclusion criteria for the purposes of reviewing a presumably sparse literature). Most importantly, so long as it targeted a mental health problem, any intervention retrieved in these searches was eligible for inclusion in this review, even if the intervention was designed and/or administered by paraprofessionals, traditional healers, or other natural helpers (i.e., we did not exclude studies describing treatments that were professionally unconventional).

Results

Computerized and manual searches of the literature yielded about 3500 initial citations that were later distilled to a corpus of 56 articles and chapters related to Native-specific mental health programs, interventions, and treatment approaches. This literature was nominally classified as follows: (a) randomized or controlled outcome studies ($n = 3$), (b) nonrandomized or uncontrolled outcome studies ($n = 6$, (c) intervention descriptions ($n = 14$), (d) summary intervention overviews ($n = 2$), (e) clinical case studies ($n = 7$), and (f) intervention approaches ($n = 24$). By way of brief summary, this literature described the following kinds of efforts: prevention of maladaptive adolescent behaviors and suicide through the cultivation of coping skills and prosocial competencies; treatment of depression, trauma, and sexual abuse through both conventional and innovative therapeutic methods; application of extended family therapy, relaxation and assertiveness training, eye movement desensitization and reprocessing therapy, and stimulus fading procedures in single clinical cases; and implementation of innovative service delivery efforts within mental health treatment systems and settings in Native American communities (a complete categorized list of these citations is available from the authors).

Of particular relevance to the identification of EBP for mental health problems were the nine outcome studies. The remainder of the citations may be interesting and useful from the perspective of documenting programs or treatments that have been offered to American Indians and Alaska Natives, enhancing therapeutic techniques toward possible increased effectiveness with Native American clients, or designing novel and alternative helping interventions for mental health problems experienced by Native people, but none of these speaks to the question of rigorously demonstrated therapeutic outcomes raised by advocates of EBP. It is nevertheless interesting to note that the vast majority of these citations are not explicitly concerned with the assessment of therapeutic outcomes at all. Nearly half of the citations are observation or reflection pieces comprised of suggestions and recommendations for improving therapeutic services for Native Americans (with particular emphasis upon the distinctive cultural transactions, alternative community-based programs, and innovative organizational ecologies that might better suit Native American worldviews and experiences). In short, very few of these articles and chapters are empirical reports, and thus their value for identifying Native-specific, evidence-based mental health treatments is extremely limited.

Of the nine outcome studies classified above, six (Centers for Disease Control & Prevention, 1998; Diken & Rutherford, 2005; Husted, Johnson, & Redwing, 1995; Kahn, Lewis, & Galvez, 1974; May, Serna, Hurt, & DeBruyn, 2005; Nebelkopf & Penagos, 2005) reported pre and postintervention results for a treatment group with no untreated group for comparison, thereby rendering valid inferences about the causal relationship of intervention to outcome in these instances uncertain. For example, May, Serna, Hurt, and DeBruyn (2005) reviewed the apparent benefits of a reservation-based suicide prevention effort (earlier described by the Centers for Disease Control & Prevention, 1998) using epidemiological data obtained annually during the course of the intervention. Their conclusion that the marked decline in reservation-wide suicidal gestures and attempts throughout this period "is indicative of the program's success" (p. 1238) is plausible but not irrefutable. Similarly, Diken and Rutherford (2005) implemented an established secondary prevention program for early onset child antisocial behavior, the *First Step to Success* (Walker et al., 1997), with four Native American children in a reservation-based school system. By using the children's preintervention antisocial behaviors as the baseline for postintervention comparison, this effective-

ness study demonstrated that an already supported intervention could be used effectively with this small sample of school-aged reservation children. Of course, evaluation of the program with a larger sample would be necessary before concluding that the intervention was empirically supported for use with Native Americans more generally.

Beyond these six articles, an additional outcome study reported the efficacy of a pharmacotherapy (methylphenidate) rather than a psychological intervention for comorbid ADHD and fetal alcohol syndrome among four Native children (Oesterheld et al., 1998). Similar to the antisocial behavior intervention just described, this effectiveness study tested an established treatment with a small number of Native Americans in order to explore transportability. Finally, no literature was identified through these searches that attempted an assessment of outcomes for Native American traditional healing or other culturally grounded ceremonies targeted at mental health difficulties (see Gone & Alcántara, 2006). In sum, the entire search for Native-specific mental health interventions yielded only two controlled outcome studies with adequate sample sizes and interpretable results vis-à-vis the concerns of EBP advocates. Manson and Brenneman (1995) reported outcomes for an intervention undertaken to prevent clinical depression among older American Indians encountering health-related stressors in the Pacific Northwest. LaFromboise and Howard-Pitney (1995) reported outcomes for an intervention undertaken to prevent suicide among adolescent American Indians through life skills training in a school-based program in the American Southwest. Each of these *preventive* (as opposed to *rehabilitative*) interventions is described in further detail below, though it is worth noting at the outset that neither study achieved the methodological rigor to qualify as an RCT.

Manson and Brenneman (1995) adapted the mainstream, well-established, and empirically supported Coping With Depression course (Lewinsohn, Hoberman, & Clarke, 1989) for use with older Native American adults at risk for depressive symptomatology as a result of deteriorating health. Comprised of 16 weekly 2-hr sessions, the adapted curriculum emphasized skills training toward progress in four areas: rehearsed relaxation, increased pleasurable activity, improved patterns of thinking, and cultivated social skills. In order to decrease the potential stigma of an intervention related to "mental health," the program was offered though a local tribal college for adult education credit. Participants received tuition remission in the amount of $10 per each session attended. Curricular resources included lectures, class activities, homework assignments, a textbook, and local community members who were trained as instructors. Curricular materials were modified slightly for increased cultural relevance for this sample. Twenty-two participants (aged 45+, 19 females) from four Pacific Northwest reservations who reported moderate depressive symptoms and diagnoses of diabetes, arthritis, or coronary heart disease were randomly assigned to the treatment condition, while 26 participants comprised the wait-list control group—because the sampling strategy involved recruitment of only a subset of participants initially assigned at random to the intervention condition, the design was quasi-experimental in nature. Participants were assessed with a health-screening interview consisting of a host of relevant indicators (e.g., subjective health status, life satisfaction, depressive symptoms, and so on) pre and posttreatment. Outcomes demonstrated that the treatment group experienced decreased depressive symptoms, decreased involvement in unpleasant events, and increased involvement in pleasant events (but did not report greater life satisfaction) in comparison to the wait-list control group, which evidenced statistically significant trends in the opposite direction for each of these indicators. Thus, despite the quasi-experimental nature of their research design and a relatively small sample size, Manson and Brenneman presented reasonably compelling evidence in support of the efficacy of their adapted Coping With Depression course for preventing depressive symptoms among older Native Americans confronted with chronic health problems.

LaFromboise and Howard-Pitney (1995) developed the *Zuni Life Skills Development Curriculum* for use with high school students at risk for suicide in the Zuni Pueblo in New Mexico. Comprised of close to one hundred sessions offered three times weekly over the course of an academic year, the curriculum emphasized skills training toward progress in seven areas: identifying emotions, building self-esteem, increasing communication and problem solving, eliminating self-destructive behavior, receiving suicide information, obtaining suicide intervention training, and setting goals. The curriculum—grounded in mainstream life skills training designed to prevent high-risk adolescent behaviors—was developed in close collaboration with community members to target risk factors for suicide and to ensure cultural relevance. Sixty-nine students in four classes were assigned to the treatment condition, while 59 students in four classes were assigned to the no-treatment control group. Since neither students nor classes could be randomly assigned to these conditions (owing to institutional constraints), the design was quasi-experimental in nature, apparently requiring pretreatment matching on the depression variable in order to attain group equivalence (unfortunately eliminating depression as an outcome measure). Participants were assessed with a self-report survey consisting of a host of relevant indicators (e.g., suicide probability, feelings of hopelessness, depressive symptoms, etc.) pre and posttreatment. Outcomes demonstrated that the Life Skills participants were less suicidal, less hopeless, and more skillful at suicide intervention and problem solving (but not more self-efficacious) in comparison to the control group, though the attrition of roughly one quarter of the original sample by the time of administration of the posttreatment assessment complicates the interpretation of these results. Nevertheless, LaFromboise and Howard-Pitney achieved a remarkable degree of success in pioneering a collaborative and culturally grounded preventive intervention for over 100 Native adolescents in a reservation school system. The curriculum is publicly available, and the intervention has been designated a "model program" by the Substance Abuse and Mental Health Services Administration in the U. S. Department of Health and Human Services.

Two quasi-experimental prevention outcome studies notwithstanding, the results of our systematic bibliographic database searches attest to the rampant tendency of mental health professionals and researchers to critique conventional treatment modalities in order to recommend what are envisioned as more culturally relevant or sensitive—and therefore presumably more effective—service delivery options for Native American clients. In the absence of compelling empirical evidence indicating which treatments impart the most significant benefits to distressed Native people, however, proponents of EBP insist upon caution and restraint in terms of professional endorsement of untested approaches and practices—no matter how promising or innovative—until rigorous evaluations are undertaken and reported in

the literature. What then is the mental health practitioner to do when the press for adoption of EBP is frustrated by a scant empirical record?

Discussion

In the autumn of 2004 the One Sky Center, a federally funded national resource center for American Indian and Alaska Native substance abuse and mental health services located at the Oregon Health and Science University, sponsored an intimate gathering of mental health researchers, practitioners, and policymakers with decades of collective experience in the arena of Native American mental health service delivery to discuss and debate the state of professional knowledge relative to EBP for indigenous populations. Scholarly presentations summarizing various facets of this knowledge base were commissioned as the means to facilitating our collective deliberations. In addressing the Native-specific mental health outcome literature for the more prevalent problems afflicting Indian country, we reported that the two quasi-experimental outcome studies described above provided the only empirical outcome evidence in over three decades of scientific literature. From an EBP standpoint, we concluded that, in the absence of compelling empirical evidence demonstrating which treatments impart the most significant benefits to distressed Native people, caution and restraint regarding professional endorsement of untested approaches and practices were indicated until such time as more rigorous evaluations were undertaken and reported in the literature.

The debate that ensued was illuminating. One (usually implicit) point of contention was the epistemological status of evidence offered in support of claims about the efficacy of Native-specific interventions. Although nearly everyone agreed that mainstream, conventional mental health and substance abuse treatments required adaptation of one kind or another prior to implementation with Native clients, consensus regarding the value and utility of scientific outcome assessments was more elusive. In the course of additional presentations typically noting the absence of empirical outcome evidence for Native-specific programs and therapies, some members of the workgroup asserted with escalating impatience, "But we already *know* what works in our communities, it's just a question of getting the federal funding agencies to acknowledge this expertise." Clearly, these individuals believed that professional training, theoretical orientation, accumulated experience, clinical intuition, and personal preference were sufficient for inferring causal relationships between clinical intervention and therapeutic outcome. As a result, they considered the EBP movement—with its increasing control of mental health resources at all levels of health care service delivery—as just one more example of European American arrogance and intrusion into the affairs of sovereign tribal Nations. In contrast, other participants in the gathering credited the EBP movement with facilitating greater accountability for claims of therapeutic efficacy, thereby providing a fundamental protection to vulnerable American Indian and Alaska Native clients in the context of the therapeutic triad.

The implications of these contrasting epistemological positions are indeed profound. If, on the one hand, professionals and researchers "already know" what works in tribal communities, then the challenge before us is merely to persuade and/or compel those who control mental health resources either to abandon the EBP standards they have embraced or to afford exceptions to those standards for service delivery in Native American contexts. Such an endeavor is not principally scientific but political in nature. On the other hand, if we remain fundamentally skeptical of our cognitive capacity to infer therapeutic cause and effect in the absence of rigorous scientific controls, then the challenge before us is instead to determine how to conduct such inquiry and report the resultant evidence toward the development of a corpus of Native-specific EBP in mental health treatment. For a variety of reasons, this endeavor is both scientific and political in nature, with the ultimate arbiter of decisions and recommendations being the quality and credibility of the science in question. We suspect that our own skepticism regarding human cognitive capacity to render complex causal inferences in therapeutic contexts is by now apparent and accounts for our appreciation of the EBP movement. We therefore recognize a pressing urgency to develop a robust empirical literature pertaining to intervention outcomes in the arena of Native American mental health. Nevertheless, we simultaneously believe there to be substantive reasons for reconsidering the call to EBP in Native American mental health service delivery.

Proponents of the "we already know" position might point to several limitations and contradictions that have yet to be resolved within the EBP movement, especially as it prepares to assimilate mental health service delivery within Native American communities. We have already briefly noted concerns among mental health professionals and researchers regarding the external validity or generalizability of the outcomes of RCTs relative to actual clinical practice. That is, in order to isolate the causal relationships involved in such experimental research, the conditions in RCTs are often quite "artificial" compared to "real world" service delivery—for example, participants might be selected because they suffer only from the disorder of interest (while most patients suffer from additional "comorbid" disorders as well), or clinicians might be monitored for their adherence to the treatments being tested (while the practices of most licensed clinicians are not scrutinized at all), or psychological changes associated with treatment are rigorously assessed with objective tests and measures (while many therapists do not employ standardized outcome measures of any kind). Even though these decisions help to ensure that psychological scientists can interpret research results relative to the causal relationships of interest, it is important to note that they also rearticulate the therapeutic encounter in ways that may or may not easily generalize to workaday professional practice. Some clinical researchers have even suggested that these and related limitations require a "local clinical science" that does not depend on nomothetic outcome evidence (Stricker & Trierweiler, 1995).

Thus, concerns regarding external validity seem intuitively legitimate in many instances, including those involving the transfer of treatments evaluated with middle-class European American samples to working class or poor populations of color in the United States (though the actual cross-cultural portability of a given treatment is itself an empirical question). At a minimum, then, the demonstration of positive therapeutic outcomes for an intervention through RCTs (i.e., the establishment of therapeutic "efficacy") is only the first phase in identifying EBP; a second crucial empirical endeavor is the establishment of parameters regarding the range of conditions and contexts in which the established causal relationship between intervention and outcome remains intact (i.e., the establishment of therapeutic "effectiveness" [see Lambert &

Ogles, 2004]). Within the mental health EBP movement thus far, this second phase has rarely been undertaken, particularly in regard to the portability of designated empirically supported treatments (ESTs) to U. S. ethnic minority clinical contexts (though the Diken & Rutherford [2005], Manson & Brenneman [1995], and Oesterheld et al. [1998] studies all represent this sort of endeavor). And, of course, both efficacy and effectiveness studies depend on the reliable and valid assessment of psychological attributes and outcomes, an endeavor only infrequently investigated among Native American respondents (see Waldram [2004] for a critical review).

A second, substantive set of critiques and concerns addressed to the mental health EBP movement asserts that the designation of the RCT as the gold standard for the evaluation of pharmacological interventions in medicine cannot be meaningfully extended to the evaluation of psychotherapeutic interventions in the mental health professions (Peterson, 1996, 2004; Wampold & Bhati, 2004). The nuances of this debate are well beyond the scope of this article, but critics of the EST movement in professional psychology argue that the provision of psychotherapy to distressed clients differs substantially from the so-called "medical model" of physicians harnessing medical technologies for the treatment of their patients' diseases in several ways. For one, there really is no psychotherapeutic equivalent to the placebo of pharmacotherapy research since the psychological aspects of the client's experience, the presumed engine of the placebo effect, are precisely the targets of intervention in most circumstances. Indeed, the causally effective or "active" ingredients of a psychotherapeutic intervention have been difficult to isolate empirically. For another, the difficulties that motivate individuals to seek psychotherapeutic treatment may not best be conceptualized as diseases in the standard medical sense insofar as the experience and expression of such problems tend to be mediated much more intensively by meaning. Indeed, effective intervention in mental health contexts may involve a great deal more than merely ameliorating "symptoms" of postulated psychiatric "illnesses." Finally, critics have amassed a sizable body of empirical evidence to support their contention that specific treatment procedures or techniques employed by mental health professionals do not account for therapeutic change as much as the kind and quality of the therapeutic relationship (and other factors common to all psychotherapies) between clinicians and their clients (Norcross, 2002). Rather than ESTs, these critics argue that mental health professionals should pursue EBP by prescribing empirically supported therapeutic relationships (ESTRs) instead of specific clinical techniques (and emphasis on healing relationships is likely to resonate with traditional therapeutic approaches in many Native communities [Gone, 2007b; Gone & Alcántara, 2006]). In sum, according to these critics, the complexities of cause and effect in the context of psychotherapeutic intervention remain irreducible to overly simplistic technique-to-disorder outcomes (see Lambert, 2004, for an exhaustive review of these and related issues).

Finally, an even more radical perspective on Native-specific mental health intervention in particular would emphasize the current "postcolonial" political context of American Indian and Alaska Native mental health service delivery (Duran, 2006; Duran & Duran, 1995; Gone, 2003, 2004a, 2004b, 2007a, 2006a, 2006b, in press a, in press b, in press c, in press d). That is, the state of the art in regard to mental health intervention in the 21st-century United States raises a series of political and ethical predicaments for Indian country, including the problem of cultural divergence in the context of persisting power asymmetries. More specifically, the culture of the mental health clinic is *not* the culture of the reservation community (Gone, in press b). And despite the burgeoning professional call to an increased "multicultural competency" in the delivery of psychotherapeutic services, few mental health professionals have fully interrogated the Western cultural ideologies that articulate and configure contemporary clinical conventions, or the assimilative transformations in non-Western selfhood these might effect (Gone, in press d). Such powerful ideological contrasts ensure that many contemporary reservation residents remain suspicious of conventional clinical services and decline to consult mental health professionals who perhaps unwittingly propose to "brainwash" them forever so they can become like Whitemen.

In contrast, in many Native communities, the contemporary status of American Indian "mental health" remains significantly caught up in history, culture, identity, and (especially) spirituality, all within the devastating context of European American colonialism. For example, Traveling Thunder—the elder whose words introduced this article (Gone, in press c, in press d)—explained that drinking, depression, and other mental health problems on the Fort Belknap reservation are directly resultant from the loss of sacred custom and teaching due to the European American "genocide" and forced "civilization" of Indian people. In such circumstances, the "medical model" for redressing the psychological problems of Native Americans seems almost irrelevant, given that epidemic rates of distress and dysfunction that afflict too many reservation communities clearly originated in the historical moment of U.S. colonial conquest and domination. A clear question thus arises: are the solutions to these seemingly existential exigencies properly formulated in terms of health care interventions? Certainly, Traveling Thunder identified the solution not as more or better mental health services (which he skeptically dismissed as a modern form of neo-colonial "brainwashing"), but the return to sacred tradition and practice (from which a renewed sense of purpose, source of coherence, and semblance of continuity might be fashioned).

Within this radical reframing of contemporary Native American mental health problems, the role of EBP and its significance vis-à-vis the therapeutic triad would seem to be of marginal relevance. Instead, mental health professionals dedicated to assisting American Indian communities might seek to embrace new kinds of roles and relationships with the people they seek to serve. Rappaport and Seidman (1983), who advocate a community psychology approach to psychological ills, have outlined several distinctions between traditional clinical services and community mental health approaches and traced the implications of these distinctions along a continuum of mental health service delivery. For example, instead of extended psychotherapy, the strategy of service in community mental health is aimed at reaching large numbers of people through brief consultations and crisis intervention; instead of the clinician's office, the location of intervention is practice in the community; instead of assuming an intrapsychic cause of disorder, the etiological factors of interest are the environmental causes of maladaptation; instead of rehabilitative services or "treatments," the type of service delivery is often preventative in nature; instead of professional control of mental health services, the locus of decision making is shared responsibility between professionals and community members; and so on. Al-

though the profound implications of an approach grounded in community psychology for Native American mental health service delivery are beyond the scope of this article (but see Gone, 2003, in press d), they certainly suggest important alternatives in terms of professional roles and relationships that might render the current discourse of EBP less salient even as they promise greater progress toward effectively redressing the postcolonial ills of contemporary Native American societies.

And yet, we hasten to acknowledge that beyond the potentially demoralizing challenges for Native communities represented by the crippling degree of postcolonial distress on the one hand and the ideological peril of conventional therapeutic efforts on the other, there lies a third domain of (paradoxical) convergence. If the solution to local distress is local innovation in therapeutic approach and direction, how might mental health professionals and researchers (and even skeptical community members) conclude that such innovations are in fact causally efficacious with regard to their desired outcomes? Thus, even if EBP within the conventional framework of mental health service delivery reaches its limits in Indian country, progress through alternative locally grounded interventions may still need to be charted through a rigorous scientific assessment of purported outcomes. In sum, as one of us has elsewhere observed, Native American communities may require "a great deal more of the kinds of professional mental health services that do not yet exist" (Gone, 2003, p. 228).

Conclusion

As this review has hopefully made clear, the EBP movement within the mental health professions has contributed much to clinical practice, providing therapists with scientific outcome evidence to substantiate their claims of efficacy for many state-of-the-art mental health interventions. A systematic survey of the scientific literature, however, indicates that treatment outcomes have not been empirically assessed or reported for American Indian or Alaska Native persons suffering many prevalent forms of debilitating psychological distress. What then are mental health professionals who are dedicated to service delivery with Native American people to do? We have briefly discussed a variety of possibilities, ranging from additional investment in efficacy and effectiveness studies of Native-specific clinical interventions to the professional adoption of alternative roles and relationships well outside of the framework provided by the therapeutic triad. In the end, these alternatives are together united by the scientific call for supporting professional claims through the empirical demonstration of positive therapeutic outcomes. To the extent that this epistemological commitment drives the EBP movement, its advocates have something important to contribute toward personal and communal healing in 21st-century Native America.

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