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Alcohol Treatment in Native North America: Gender in Cultural Context

ERICA PRUSSING, PhD
Department of Anthropology, University of Iowa, Iowa City, Iowa USA

JOSEPH P. GONE, PhD
Department of Psychology, University of Michigan, Ann Arbor, Michigan USA

Using ethnographic findings from two community-based substance abuse programs for indigenous peoples in the United States and Canada, this article examines how greater attention to cultural context can help to inform the treatment of alcohol problems among Native North American women. Cultural context shapes not only therapeutic activities and interactions within substance abuse programs, but also how such programs develop within different communities. These findings add to the growing evidence that gender can powerfully shape how Native American clients engage spiritual resources and respond to conventional styles of psychotherapeutic talk, supporting emergent efforts to rethink "cultural competency" in mental health services for Native North Americans.

KEYWORDS Substance use therapies, Native Americans, gender, cultural competence

Using ethnographic findings from two community-based substance abuse programs for indigenous peoples in the United States and Canada, this article examines how greater attention to cultural context can help to inform the treatment of alcohol problems among Native North American women. By exploring the ways in which gender figures within the variety of culturally informed ideas, priorities, and experiences that shape how Native American clients encounter therapeutic interventions for alcohol, this analysis con-

Address correspondence to Erica Prussing, University of Iowa, Department of Anthropology, 114 Macbride Hall, Iowa City, IA 52242-1322. E-mail: erica-prussing@uiowa.edu

tributes to emerging efforts to rethink conventional approaches to "cultural competence" within mental health services.

Although the term resists consensual definition (Sue, Zane, Hall, & Berger, 2009), *cultural competence* can be summarized as "attributes or characteristics of service providers (and, sometimes, service agencies and organizations) that equip them to effectively provide otherwise desirable or warranted health care interventions to an array of culturally diverse patients or clients" (Wendt & Gone, in press). As we argue here, experiences of staff and clients in Native North American substance abuse programs highlight the complexity and variability of the local worlds of meaning and social experience that shape how such programs figure in community members' transformations from drinking to sobriety. Attending closely to these local worlds, we suggest, can constructively challenge key assumptions about the nature of cultural difference as well as about psychotherapeutic intervention that underwrite many current formulations of cultural competency.

Critiques of well-intentioned but problematic efforts to promote cultural competence in mental health services have emerged in both clinical/cultural psychology (see Wendt & Gone, in press) and medical/psychological anthropology (see Kleinman & Benson, 2006). Critics take issue with essentialized and overgeneralized conceptualizations of cultural influences on health-related behaviors (i.e., the notion that cultural differences can be assessed through checklists of beliefs and behaviors that are allegedly specific to particular ethnic groups). Critics also emphasize the common but misleading notion that culture is a feature of clients rather than practitioners (i.e., the ethnocentric fallacy that "our" knowledge is simply truth whereas "theirs" is more fully influenced by culture). An alternative perspective adopts a more processual view of how culture shapes the experiences of mental health problems and psychotherapeutic interventions, actively recognizing that cultural influences are variable and changing. Such views also emphasize the diversity in members of cultural communities by locally salient social features (such as gender, age, etc.), as well as by individual psychological factors. In so doing they call for rethinking fundamental assumptions that underwrite psychotherapies themselves, moving beyond how many current cultural competence efforts limit their focus to the actions and sensibilities of therapists or the ambience of clinical settings. Wendt and Gone (in press) specifically emphasize the need to distinguish between general clinical competence and cultural competence in psychotherapy, and call for "shift[-ing] focus away from culturally competent therapists toward culturally commensurate therapies."

Needs for culturally appropriate mental health services are commonly recognized for a variety of populations (Department of Health & Human Services, 2001), including Native North Americans (Nebelkopf & Phillips, 2004). Yet Native communities demonstrate the need for close and localized attention to what constitutes culturally commensurate therapies for a

given time, place, and people, as well as to the broader political-economic and historical forces that shape community-based efforts to implement such therapies. Communities vary widely in their responses to the challenges of navigating between localized needs and resources on the one hand and widely available therapeutic approaches on the other, for example. The two community-based substance abuse programs that we describe here illustrate the very different forms that such programs currently take in Native North America. In a process that has become especially visible in the past several decades, indigenous communities worldwide are working to decolonize their health services by considering how the causes of health problems reflect colonial legacies, including the multigenerational effects of past violence and dispossession as well as current experiences of economic, social, and political marginalization (Duran & Duran, 1995; Warry, 1998). These efforts are centered on better accommodating local conceptualizations of health problems and local resources for healing in community health services. Our ethnographic examples document the multiple ways in which these ongoing processes inform community-based programs to address alcohol problems in Native North America.

Fully addressing such multifaceted and variable needs requires more detailed understandings of exactly how localized cultural contexts can affect psychotherapeutic interventions. Regarding alcohol, for example, community members may imbue drinking and sobriety with local meanings that circulate, interact, and produce social consequences that in turn generate new layers of meaning, in an ongoing process that influences how, why, and to whom particular therapeutic approaches might appeal at any given point in time. In contemporary Native North America these localized politics of meaning can take different forms and affect substance abuse services in distinctive ways. A small but growing body of work (Baird-Olsen & Ward, 2000; Fast, 2002; Prussing 2007, 2011) suggests that gender can significantly inform these cultural complexities. Closer attention to these dynamics calls for rethinking generalized characterizations of the treatment needs of "Native American women," and developing a more nuanced understanding of women's experiences as members of complex and variable cultural communities.

Although gender is clearly included in current efforts to promote accommodation of cultural diversity in health care arenas ranging from psychiatric practice (Andermann, 2010) to nursing education (Abrums & Leppa, 2001), we suggest here that closer ethnographic study illuminates how local worlds of meaning can produce gendered patterns in the appeal of substance abuse interventions as well as in the consequences of sobriety. Attending to such processes calls for broadening the range of questions that need to be asked as part of efforts to accommodate cultural diversity in interventions for alcohol and other substance use problems.

Our analysis draws centrally upon ethnographic illustrations that highlight how spirituality and talk figure within the services of two community-

based substance abuse programs in Native North America.[1] Our first example focuses on explicating the problems with conventional formulations of "cultural competence" in the provision of substance abuse services, whereas the second example extends these insights into a more detailed ethnographic analysis of how gender figures within psychotherapeutic interventions for alcohol. Both examples emphasize how conceptualizations of cultural diversity and of psychotherapeutic intervention itself are enriched through closer attention to local perceptions, experiences, and priorities within Native communities.

Assessing the cultural fit of particular therapeutic approaches involves attending to the fact that community members themselves have understandings of when and how behaviors like substance use become pathological, perspectives on the multiple local meanings that can accompany psychological and behavioral changes, and experiences of the local social consequences (desired, expected, or not) of changing behaviors such as drinking. Ethnographic research begins from the standpoint that community members are the experts regarding these localized cultural worlds. Using this central research method from cultural anthropology, our analysis elaborates upon long-standing and newly emergent themes in anthropological approaches to understanding alcohol use and the treatment of alcohol problems.

CULTURALLY CONTEXTUALIZING ALCOHOL AND GENDER: ANTHROPOLOGICAL PERSPECTIVES

Anthropologists' efforts to observe and understand alcohol use (Douglas, 1987; Heath, 2000; Marshall, 1979; Marshall, Ames, & Bennett, 2001) have facilitated the discipline's connections with other academic fields and professions (Heath, 1987; Marshall, 1990), including psychology and public health. Anthropological approaches to alcohol show distinctive tendencies to complicate common assumptions about alcohol use and alcohol-related problems, by questioning the validity of diagnostic measures and clinical interventions that are exported into diverse cultural communities, and by examining how drinking practices can serve important cultural and social purposes. Anthropologists have also considered how transformations of drinking behavior are often historically situated and socially patterned within

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communities (e.g., see Brady, 1995; Brandes, 2002; Eber, 2000; Kunitz & Levy, 1994; Marshall & Marshall, 1990; Quintero, 2000; Spicer, 2001). Related scholarship about psychotherapeutic processes in other disciplines, such as cultural psychology, has emphasized similar concerns.

The wide-ranging impact of feminist theory and gender studies has been clearly felt within medical anthropology, highlighting how gendered ideas and practices work among other cultural influences on experiences, perceptions, and practices in relation to health (e.g., Lock & Kaufert, 1998). A growing number of ethnographic studies consider the complex ways in which cultural constructions of masculinity and femininity can influence attitudes and practices surrounding drinking and sobriety (Borovoy, 2005; Brandes, 2002; Eber, 2000; Heath, 1991; Marshall, 1978; Marshall & Marshall, 1990; Prussing, 2011; Suggs, 2001).

Heath (1991) especially made the case that ethnographic findings about women and alcohol challenge popular but problematic generalizations, such as the notions that women universally drink less than men, suffer more adverse consequences, or are far more likely to suffer from additional mental health problems compared to men who drink. He described how instead, cross-culturally women seem to hold a variety of relationships with alcohol and are often involved in its production and distribution as well as consumption. Questions about when and how drinking becomes pathological for women thus need to be carefully constructed while considering the cultural and historical circumstances of given times and places. Such care is especially needed in studies of women and alcohol in Native North America, where popular and researcher attention often selectively focus only on highly pathological involvements with alcohol.

UNDERSTANDING ALCOHOL USE AMONG NATIVE NORTH AMERICAN WOMEN: CURRENT NEEDS

Despite decades of critique and counterevidence from anthropologists and other social scientists (Leland, 1976; May, 1994), popular stereotypes about drinking in Native North America (e.g., "drunken Indian" imagery and associated ideas of universal susceptibility and pathology) remain widespread. Corrective efforts to document the diversity of drinking practices between and within Native North American communities include efforts to examine gender (Beals et al., 2009). These studies find considerable variation in Native women's involvements with alcohol, but researchers and popular media (e.g., Dorris, 1990) focus heavily on psychopathological dimensions of women's drinking and severe consequences such as fetal alcohol syndrome (FAS). Yet evidence suggests that ethnicity may well be an inaccurate marker for more valid risk factors for FAS such as poverty and malnutrition, raising troubling questions about how and why this outcome has been

linked so closely to Native North American women (see also Lock & Vinh-Kim, 2010, p. 71). Although FAS and other serious alcohol-related problems certainly warrant attention, so does understanding how they figure among other patterns and consequences that characterize Native women's drinking. Asking more and better questions about how Native women pursue sobriety and respond to therapeutic interventions, for example, also seems to be a pressing research need with potential for high public health impact.

As we turn to these questions now, we acknowledge that a variety of resources are available and used by Native North Americans seeking help with alcohol problems but focus here on institutionalized substance abuse services in two Native communities. Although recognizing that the associated processes of therapeutic intervention and behavior change also have multiple dimensions, we focus here on spiritual practices and styles of talk as salient issues raised by members of the communities studied, and to illustrate the types of research and clinical questions that can result when one considers how programs to promote sobriety unfold in localized cultural worlds.

THERAPEUTIC PRACTICE IN NORTHERN MANITOBA

In recent research, Gone (2009, 2011) explored the principles and practices that structured therapeutic activities in a nationally accredited, tribally controlled substance abuse treatment center on a northern Manitoba First Nations reserve. This center, or Healing Lodge, provided distinctive inpatient, outpatient, and referral services for an almost exclusively First Nations clientele drawn from throughout much of western Canada. The entire staff at the Lodge consisted of First Nations employees, most of whom were members of the local northern Algonquian reserve. The focus of Gone's 7-week period of participant observation was the outpatient program that assisted clients drawn from the reserve community. This program—comprising four staff and up to a dozen clients per 10-week treatment cycle—had been funded by Canada's Aboriginal Healing Foundation (AHF) starting in 2000 and continuing up through the time of Gone's research in 2003 to 2004. In fact, Gone's study was commissioned by the AHF for purposes of documenting funded community strategies for redressing the devastating psychosocial legacy of the oppressive residential school system in Canada. Alcohol abuse and dependence were identified as a primary consequence of this legacy—indeed, the vast majority of the staff and clients interviewed by Gone for the project had experienced serious problems due to their drinking at one time or another (see Gone, 2008b, for much more detail, including relatively thorough incorporation of staff and client interview material solicited for the project).

Therapeutic Activities

The goal of Gone's (2009, 2011) investigation was to describe the therapeutic activities of the AHF-funded outpatient program and to ascertain the treatment model or philosophy as it was understood by program staff and clients. The therapeutic activities of the outpatient program can be traced to nonindigenous treatment models based on the 12 Steps of Alcoholics Anonymous (AA), but with many local alterations. Program clients participated in 3 hours of facilitated activities on four nights per week. Treatment sessions typically comprised various components, including opening and closing prayers, psychoeducation, associated group exercises, sharing circles, and words of encouragement. Psychoeducation included a range of "life skills" topics, such as alcohol and drug awareness, family dynamics, grief and loss, and assertive communication, as well as a robust orientation to basic northern Algonquian "traditional" knowledge such as the seven sacred values or the meaning of the sweat lodge. Associated activities included a variety of exercises, such as tracing one's family history, writing a letter to a deceased loved one, or discussing an educational film. Sharing circles adhered to the sequential monological template of AA, but with pan-tribal embellishments such as the passing of a ritual object for turntaking. Activities were conducted primarily in English and occasionally in northern Algonquian, though all staff and clients at the time of the research were fluent in English.

Beyond the nightly outpatient sessions, clients were encouraged to also participate in one-on-one counseling sessions by appointment during the week with their assigned counselors—some clients found these to be extremely helpful, whereas others chose not to partake at all. In addition, all clients were invited to participate in traditional cultural and ceremonial activities sponsored by Lodge staff as opportunity arose. For example, a designated "cultural counselor" who was employed by the inpatient program conducted weekly sweat lodges at the center each Thursday afternoon. Beyond the institutionalized sweat ceremonies, Lodge staff also intermittently sponsored blessing rites, pipe ceremonies, and annual fasting camps. Interestingly, Lodge staff members were also quite enthusiastic about a range of therapeutic approaches and activities that were not only nonindigenous but also beyond the scope of typical substance abuse treatment. These "complementary and alternative" (and even New Age) treatment approaches (e.g., neurolinguistic programming, energy therapies) were valued because of their overtly spiritual character (which was also why AA was valued). By contrast, there was neither adoption of nor interest in what are termed evidence-based practices or empirically supported treatments for substance abuse. Finally, clients were routinely invited to community events and activities sponsored by the program staff. These included feasts, gatherings, and sharing circles designed to heighten community consciousness about the history of the

residential schools and the deleterious consequences of these schools on family and community life.

Treatment Philosophy

In light of the wide diversity of therapeutic approaches and activities in evidence at the Lodge—12 Steps, indigenous ceremonies, anger management, inner child work, neurolinguistic programming—a key question that arose was whether and how these might be integrated into a coherent treatment philosophy. Indeed, coherence was afforded by the First Nations symbol of the medicine wheel. The pan-tribal medicine wheel is represented as a circle bisected by perpendicular lines that form four interior quadrants. The symbol is conventionally interpreted as referencing four-in-one phenomenon in spatial terms (e.g., the four cardinal directions), as well as tracing cyclical time through four stages around the circumference of the wheel (e.g., the four seasons of the year). The key conceptual advantages of the medicine wheel are said to be holism and balance. In the context of substance abuse treatment, then, the four-in-one domain was applied to the four constituents of human existence—mind, body, spirit, and emotion—whereas the cyclical time domain was applied to the stages of human development—childhood, adolescence, adulthood, and old age. In the medicine wheel philosophy of treatment, each of these aspects required attention and understanding in light of personal problems. The promotion of consistent efforts by individuals to achieve and maintain balance between the mental, physical, spiritual, and emotional facets of day-to-day experience was considered the goal of treatment because alcohol problems and associated forms of postcolonial distress were understood to reflect lives out of balance.

One final aspect of the medicine wheel philosophy of treatment is crucial to acknowledge. Even as the medicine wheel was applied by individuals as an important means for managing personal problems such as alcohol addiction, it was also simultaneously harnessed to achieve a second therapeutic goal of central importance at the Lodge, namely the reidentification of clients with indigenous cultures and societies. This process of facilitating the "cultural renaissance of the Red Man" to combat the ethnocidal impact of the residential schools was understood locally to be the most important contribution of Lodge programming. In essence, alcohol addiction and other personal problems among First Nations people were attributed to the history of Euro-Canadian colonization, which overtly sought to extinguish indigenous cultural institutions and practices (i.e., to "kill the Indian, and save the man"). The residential schools—with their compulsory attendance, Christian indoctrination, and agricultural-industrial curricula—were the chief means for attaining this objective. Thus, local efforts aimed toward Native cultural reclamation and revitalization were seen to afford reserve residents with a distinctive and compelling sense of purpose in life that would remedy

postcolonial fractures in self and society. As a result, the medicine wheel not only afforded an orienting frame for therapeutic practices, but also designated such practices as distinctively Aboriginal in character. Moreover, the therapeutic aspirations motivating these efforts extended well beyond substance abusing clients at the Lodge to the membership of the entire reserve community.

Beyond Cultural Competence: Contextualizing Therapeutic Talk

Within health services generally, and behavioral health services in particular, the call for cultural competence among service providers has become an institutionalized commitment, in theory if not in practice. In comparison to the kinds of modifications that are usually described under the rubric of cultural competence—for example, provider awareness of personal bias, provider fluency in client language, provider knowledge of client's cultural background—the staff and program at the Lodge have clearly moved well beyond this limited form of therapeutic packaging and presentation to deliberately rethink a good many stock therapeutic assumptions in light of the community they serve. The intentional commitment to client socialization into indigenous cultural practices (with client consent, of course) was one instance of this broader endeavor, as was the effort to dissolve (or at least to diminish) the boundary between client and community. And yet, there was also evidence that, in at least one salient domain, local subscription by Lodge staff to a more conventional aspect of therapeutic practice led to difficulties in making progress with clients.

The domain in question was therapeutic talk. Everyone at the Lodge talked about talk. Counselors in the outpatient program talked about how challenging it was to conscript their clients into verbal self-expression during sharing circles. Clients talked about how intimidating—and even how overwhelming—this therapeutic mandate to talk was for them, especially (though not exclusively) within a group setting. Such instances of metacommunication thus became an analytical window for thinking about possible breakdowns or ruptures in the locally fashioned therapeutic endeavor. For example, clients reported difficulty transitioning into the outpatient program because of the mandate to talk:

> At first I didn't [feel comfortable]. The first two weeks . . . I almost walked out. . . . New [clients] come every week. . . . I knew just how they feel at first. Quiet. They don't want to talk. They talk little. That's the way I was when I first started. I was hesitant to talk. Didn't even answer a question. I wasn't comfortable to answer questions. (Frank,[2] client)

[2]All names are pseudonyms.

The staff concurred that persuading outpatient clients to talk was challenging:

> Our Native people have such a hard time talking about their emotion. How they feel. And I've seen that from as far back as I can remember.... It's just recently that I've been able to talk about how I feel.... Having worked in the last ... fifteen years in social work ... with our ... Native people, I find it's like pulling a tooth out of them. (Tom, counselor)

Interestingly, as the above quote reveals, the difficulties associated with eliciting therapeutic talk from clients seemed tied not just to client preferences but to normative behavior more generally ("Our Native people ..."). Thus, beyond individual client reluctance to revisit painful memories or even fear of social repercussions if therapeutic confidence were broken (as it sometimes was in this small-knit, face-to-face community), an intriguing alternative is suggested. This alternative is simply that long-standing sociolinguistic norms persisted in this contemporary northern Algonquian reserve setting that devalued or proscribed verbal self-expression of this kind more generally.

The evidence that supports this alternative possibility was found internal and external to Gone's study. The internal evidence included statements—principally by staff, who completed longer, more reflective, and more detailed interviews—that discussed this reticence as more generally characteristic of community life, whether historical or contemporary (such as in the quote above). (Interestingly, drunkenness was sometimes described as affording an exception to this characteristic reticence, as also did some forms of indigenous ceremony.) The external evidence for an alternative normative explanation comes from an extant literature addressed to indigenous North American communicative norms (Basso, 1990; Carbaugh, 2005; Darnell & Foster, 1988; Phillips, 1983), including those among the close linguistic kindred of the northern Algonquian community who partnered with Gone (Darnell, 1988; Preston, 1975). Darnell (1981), drawing on many years of anthropological fieldwork, tackled the issue of reticence among the eastern Crees in particular. She observed that public talk within Cree community life is normatively constrained in comparison to the "loud mouthed" *moniyaw* (or White man). Her explanation is that among Crees—as among "most American Indian groups" (p. 56)—the regard for one's own personal autonomy and the care taken to avoid infringing on that of others renders social interaction and interpersonal communication as potentially "dangerous" affairs. For example, asking direct questions presumes on others to provide answers, whether they are so inclined or not. Indirectness, ambiguity, and reticence in interpersonal interaction all follow from this commitment to protecting and preserving personal autonomy.

In this light, it seems probable that the therapeutic imperative to express personally sensitive information within the treatment setting—whether in group or one-on-one with a counselor—challenged norms governing communication in the presence of nonintimates. Given the salience of gender

as an organizing category in Native American social life, there may also be significant gender patterns that further complicate communicative behavior of this kind. Regrettably, Gone's sample comprised too few respondents to disaggregate for robust analysis of these issues by gender. It was the case that female clients talked more during their interviews with Gone ($n = 4$, $M = 9{,}621.5$ words) in comparison to male clients ($n = 7$, $M = 6{,}864.4$ words), though the longest client interview was with a man (12,335 words). Gender also appeared to be one attribute that factored into client assignment to a counselor, but the logics were not recognizably standardized (e.g., some, but not all, staff worried that romance could derail a mixed gender counseling relationship) or reliably primary (e.g., kinship might be more important than gender in making such assignments). Additionally, high-status roles in the community (e.g., Chief and Council, high-level administrators) were more generally filled by men. Historically this was true of ritual leadership and participation in this community as well, and it is intriguing to wonder at the significance of a contemporary ceremonial revitalization that had been lately promoted by male and female practitioners, including many among the staff that Gone interviewed—perhaps such ceremonialism afforded women in particular a means for local empowerment outside established male-dominated reserve institutions.

Although gender was not the primary focus of Gone's study, his work overall highlights the importance of understanding normative communication for culturally contextualizing substance abuse services like the Healing Lodge. Whether framing the matter in these terms would have persuaded Lodge staff to alter their methods is unknown, but it would not have been surprising had they simply reasserted the therapeutic value of clients learning to talk in such ways under such conditions. Indeed, the therapeutic endeavor in substance abuse and mental health treatment depends rather extensively on counseling or psychotherapy, and departing too far from the familiar could have jeopardized the Lodge's funding and accreditation. Even so, psychotherapy as a form of psychosocial intervention depends above all else on psychologically minded, self-referential talk (Kirmayer, 2007). As a consequence, there remains a second sense in which Gone's study invites consideration of moving beyond cultural competence in the cross-cultural therapeutic endeavor. More specifically, cultural competence in substance abuse and mental health services proposes to tailor psychotherapeutic intervention to the cultural needs of diverse people and communities, but only while preserving the centrality of reflexive and (usually) expressive talk as a mechanism of change. As Gone (2008a) argued elsewhere, the implicit commitment by advocates of cultural competence to preserving this basic tenet of professional intervention can present formidable problems in postcolonial indigenous societies where enduring norms governing who talks with whom (and under which conditions) depart substantially from the psychotherapeutic mandate. Such normative divergences may require

us to fundamentally move away from the notion of cultural competence as an attribute of skillful interventionists, and toward a concept of cultural commensurability as an attribute of the interventions they employ (Wendt & Gone, in press).

The example of the Healing Lodge demonstrates how even within community-based substance abuse programs that explicitly incorporate indigenous concerns into their treatment philosophy, forms of self-expression that are historically specific to "talk"-centered psychotherapies can remain institutionalized in daily practice—despite awareness of their lack of cultural commensurability, expressed among program staff and clients. Our second ethnographic example, from a substance abuse program in southeastern Montana, documents another community's rather different experiences navigating between local needs and conventional therapeutic interventions. Here spirituality also figures as an important focus of local understandings of recovery, yet ritual practices are not fully institutionalized in program services. Here too, forms of self-expression drawn from conventional psychotherapies occupy a prominent role in the program's services. Community members subject these practices to scrutiny and often vigorous debate, and many pursue sobriety through alternative means. In the cultural world of this community, Prussing found that gender powerfully shapes both this critical commentary and the associated efforts to craft alternatives.

THERAPEUTIC PRACTICE IN SOUTHEASTERN MONTANA

Through intensive ethnographic research from 1994 to 1997, a shorter follow-up study in 2005, and a number of briefer visits, Prussing (2007, 2008, 2011) examined community responses to therapeutic practices in a federally funded, tribally controlled substance abuse treatment program on the Northern Cheyenne Reservation in southeastern Montana. This project was motivated by gaps in research about how and why Native North American women drink and initiated when Northern Cheyenne health administrators responded positively to Prussing's research proposal to examine these issues. Over an 11-year period she conducted a total of nearly 4 years of participant observation and interviewing in a variety of settings on the reservation, including the "Recovery Center" substance abuse program. This work was funded through a combination of several small institutional and extramural grants, and Prussing continually consulted with Tribal Health administrators and reservation community members during all phases of gathering data and reporting/publishing study findings.

Like Healing Lodge, Recovery Center has engaged in the broad international movement in indigenous communities that aims to link substance abuse and other mental health problems to colonial legacies, and to couple

sobriety with cultural revitalization. Yet in contrast to the Healing Lodge's efforts to institutionalize these concerns, Recovery Center's services remained heavily centered on nonindigenous diagnostic and therapeutic practices during the period of Prussing's study. The reasons why are multiple and potentially include wide-ranging differences in national health care systems as well as in national politics and policy regarding indigenous rights. Also significant are political-economic pressures and institutional constraints that emerge from federally funded health care and accreditation standards (see Prussing, 2008). At Northern Cheyenne Reservation these have produced considerable tension by conflicting with culturally significant local processes for recognizing, understanding, and responding to the social and psychological diversity among community members.

By the 1970s one central therapeutic program for substance abuse problems had developed on the reservation, and by the 1990s it was known as Recovery Center. By the time of Prussing's study, Recovery Center had received accreditation from state, regional, and national agencies. The program's staff members were primarily Northern Cheyenne tribal members who had completed specialized training in chemical dependency counseling, often through a program at the local tribal community college. Their numbers shifted between the mid-1990s and mid-2000s, from a high point of more than a dozen to a low point of nearly one half that number. Therapeutic activities at Recovery Center had relied for decades on concepts and practices drawn from the 12 Steps of AA, and by the 2000s combined these with diagnostic practices and therapeutic approaches drawn from psychiatric and other biomedical sources like the *DSM* (*Diagnostic and Statistical Manual of Mental Disorders*) and American Society of Addiction Medicine.

Recovery Center's services centered on providing clients with a diagnosis of the type(s) and intensities of substance use problems, and offering clinical interventions that included individual counseling sessions, a 6-week intensive outpatient therapy group, and more open meetings that combined prevention education with therapeutic activities such as identifying and discussing one's emotions. Clients needing inpatient services were referred to residential treatment centers located in a variety of sites across the northern Plains and Pacific Northwest, many of which were oriented specifically around Native North American clientele. Whether involved in outpatient care alone or returning from inpatient treatment, Recovery Center clients were routinely encouraged to attend Alcoholics Anonymous (AA) and related 12-Step group (Al-Anon, Adult Children of Alcoholics, and Codependents Anonymous) meetings on the reservation and surrounding areas. Recovery Center also sponsored or cosponsored a number of public workshops that aimed to promote a broader process of healing from colonial legacies of multigenerational trauma, as well as to address more specific problems such as domestic violence or rising levels of methamphetamine use. Many of these

also prominently featured 12-Step elements, such as speakers "telling their story" of descent into substance abuse and eventual recovery using narrative templates derived from AA (e.g., Cain, 1991).

As Prussing discusses elsewhere (2007, 2011), gender has figured prominently in shifting patterns of clients using Recovery Center's services. Current and former program staff reported a major shift from approximately 3:1 to 1:1.5 in the male-to-female ratio of their clients between the 1970s and 1990s. By this time Northern Cheyenne women had also become highly visible in attending and leading community-based 12-Step meetings, and in organizing public workshops about topics related to addiction and recovery. Notably too, some of these women were actively involved in controversial efforts to revitalize Cheyenne spiritual and ritual practices.

Spirituality as Gendered Practice

Similar to the Healing Lodge, Recovery Center staff and clients expressed special interest in spirituality and cultural revitalization as key tools in the pursuit of sobriety. Yet Recovery Center adopted a less eclectic treatment philosophy, and discussions focused on local ritual practices such as collective annual Sun Dances, sweat lodge ceremonies for small groups, and rituals undertaken by individuals such as fasting. As such, efforts to incorporate culturally commensurate spiritual activities into the program were shaped by broader local debates about how the forms of these rituals were changing over time—and especially, about who was appropriately suited to participate in them.

Tribal health administrators emphasized that in theory, Recovery Center could institutionalize therapeutic activities based on Cheyenne spiritual practices, so long as these were documented in ways that met standards set by funding and regulatory agencies. Some staff had indeed made efforts to develop a "Traditional Component." Prussing (2008) found that this component had been initiated and discussed for over a decade, but not fully implemented as an institutionalized resource for Recovery Center's clients or incorporated into its services. Administrators, clinical staff, and clients all recognized that ritual activities were probably not suitable for all Recovery Center clients. Some administrators expressed additional concerns about the unknown clinical effectiveness of ritual practices as a response to alcohol problems (see also Weibel-Orlando, 1989). Instead of formally institutionalizing ritual activities at Recovery Center, some staff worked to refer interested clients to ritual practitioners in the community. Yet they experienced difficulty reconciling this system of referral with the patterns of kinship ties and residential proximity than normally shape how Cheyennes become involved in such activities, as well as with the fact that many knowledgeable ritual specialists also drank so might not be able to fully assist clients needing special support for sobriety.

The Traditional Component's effort to involve more community members in ritual practices also landed Recovery Center squarely in the midst of ongoing local debates about ritual participation. Recent decades have witnessed greater participation in collective and personal rituals by segments of the population whose involvement was historically limited, such as women of childbearing age and tribal members who do not speak Cheyenne. Some community members contest this broadening scope by arguing that spiritual power is dangerous unless engaged by people with specialized knowledge and skills. Such statements are shaped in turn by broader, ongoing debates about the content of Cheyenne "traditions," and about what features of community members (such as by family, gender, age, language skills, demeanor, experience, etc.) qualified involvement in traditional activities such as ritual practices. Given this ongoing local controversy, formulating a clear and coherent definition of what exactly constitutes "Cheyenne spirituality," and how clients of a substance abuse program might access it in ways that would support their sobriety, were quite daunting tasks.

Although many female clients of Recovery Center expressed interest in developing the spiritual dimensions of recovery beyond those offered by the 12 Steps' attention to a "Higher Power," Prussing's community-based ethnographic findings suggested that existing patterns of ritual participation were more accessible to men than to women. As Alice, a female counselor at Recovery Center, commented: "Traditional ways [here] are more geared towards men than women. I think they're finally opening up though, accepting more women into Sun Dance and sweats and stuff." Because Northern Cheyenne women were currently involved in this "opening up" and working to reclaim or reinvent their roles in local ritual practices, and because their efforts were eliciting considerable controversy in the community, female clients from Recovery Center who wanted to become more involved in local ritual practices needed resources at two levels. They needed to enhance not only their knowledge and skills concerning Cheyenne spirituality and ritual, but also concrete guidance in navigating through the politicized social interactions that often accompany women's participation in these arenas. Referral to ritual activities run exclusively by and for women, or close relationships with individual sponsors who could successfully guide less experienced women through these processes, were possible strategies for doing so. Yet providing such resources for any woman entering Recovery Center who wanted them depended on building considerable new infrastructure and then justifying it to funding and accreditation agencies, extremely difficult tasks to undertake given the limitations in financial and human resources that Recovery Center has continually experienced.

Although female clients faced special challenges in accessing Cheyenne spirituality and ritual as resources in recovery from substance abuse, Recovery Center's services did seem to appeal to more women than men. Recovery Center staff and clients, male and female, explicitly offered explanations for

this pattern that emphasized how the forms of self-referential, emotionally expressive talk emphasized within 12 Step and related psychotherapies were more in keeping with local cultural constructions of women's roles.

Gender and Psychotherapeutic Talk

As in the northern Algonquian communities discussed by Gone above, Northern Cheyenne cultural conventions for social interaction center on expressions of respect for personal autonomy that include avoiding asking direct questions or otherwise placing pressure on someone to explicitly express their intimate personal experiences. As Prussing quickly learned, even conventionalized North American greetings that take the form of questions such "Hi, how are you?" are difficult to translate into the Cheyenne language (with the nearest equivalent having a decidedly different tone, literally meaning "Are you sick?"). When direct questions are posed to elicit personal information, Northern Cheyenne community members commonly scrutinize the qualities of the person making such a request. The assumption that training in chemical dependency qualifies someone to ask such questions is by no means widely shared on the reservation. In this small community people know a lot about each other's histories and current circumstances, and factors such as how a staff member treats their parents or deals with marital problems may figure heavily into how a prospective client evaluates the staff member's social authority to interact with them in this fashion.

Staff members, however, generally viewed encouraging clients to talk as an essential feature of their therapeutic roles. Recovery Center staff and clients described how talking serves a number of interrelated purposes for clients seeking sobriety: It helps people to learn how to deal with their feelings, to build trust, to realize that they are not alone in the problems that led them to drink, or in the problems that were caused by their drinking, and to build new support systems for their new life without alcohol. Pauline, a counselor at Recovery Center, invoked a common 12 Step (specifically Adult Children of Alcoholics) concept of "three rules" in describing how recovering from alcoholism involves learning this new form of talk:

> Coming into recovery was something I learned how to do. Because I never learned to get in touch with my feelings before because I was never taught, and I was brought up in a dysfunctional family, you know– don't talk, don't trust, don't feel, those were the three rules that I was brought up with. After I got into recovery I started learning how to get in touch with my emotions and how to work through them.

She and a range of other staff members and clients, male and female, also described these forms of talk as more accessible to women given their emphasis on emotional expression.

Such commentary frequently depicted Northern Cheyenne men as less expressive of their feelings and vulnerabilities than women. Several people used the term *macho* to describe local cultural ideologies of men's roles, and within the prevailing 12-Step framework, linked investment in such ideologies with men's general tendencies towards greater "denial" of substance abuse or other problems. Gus, a counselor and administrator at Recovery Center, described how men might quit drinking but never fully tap into the deeper recovery facilitated by 12-step-style, emotionally-expressive talk:

> I do see more women in ... recovery roles or whatever. I see men quitting but not following a 12-step program, in a way because to me it has a lot to do with showing emotion, with people being able to express themselves, and relate in that way. A lot of men here don't know what that's about.

A female counselor, Lynn, elaborated:

> The only reason I can come up with [for the gender difference] is how much more females are open anyway, more open. We have permission to cry in public where a man doesn't. With men there's a stigma with that. Women will just tell you their stuff–sexual abuse issues, domestic abuse issues. It's harder for men to do that, and to express any feelings about it. Like they won't see it as "sexual abuse," just as "experimentation" or something. Even if they talk about it they don't express any feeling about it; it's just like "yeah this happened to me."

Although such characterizations of male reticence about intimate personal topics are found in a variety of cultural contexts, indigenous and nonindigenous, other comments by Recovery Center staff and clients demonstrated that culturally specific concerns about Cheyenne masculinity and femininity were operative in community members' perceptions of 12-Step-style talk. Gilbert, a Recovery Center client, described how anger and violence accompanied his understanding of what it meant to be a Cheyenne man:

> I always had a problem with domestic violence, too, because I didn't know how to control my anger, you know. The way we grew up ... it was always, kind of, one of those characteristics of Cheyennes was they were mean dudes, you know [laughs]? That's how we grew up, you learn these roles when your parents play them, and that's what they did, you know–when they had problems with their wives they'd just slap them up. That's how I learned to deal with women. Now, when I look at it I'm not very proud of what I done, you know. I'm trying to learn how to deal with women, and respect them. I never knew how to deal with my anger. Some women talk about it, but we never had a way to tell people how you felt.

In conversations with Prussing about drinking and sobriety, men also tended to speak at greater length about "the reservation system" and problems of "dependency" than women, reflecting possible gender-specific views of the psychological causes of problematic alcohol use. As Gus commented:

> With this alcoholism, it is shame-based. It is passed down if you don't deal with it–you repeat the same behaviors, your children repeat them, and on down the line. The reservation took everything. You can't feel good about yourself with the government and the tribe taking care of you. People are ashamed of the poverty, and even of their names–like I used to get teased a lot about the way we lived and about my name when I was growing up. So I was always trying to be somebody that I wasn't, and that was a big part of my drinking.

Gilbert echoed these themes and specifically linked dependency and reservation conditions to feelings of intense anger: "I used to feel angry about our dependency on outside people. I would hear my grandparents talk about themselves as self-sufficient, how they governed themselves and stuff like that. I always felt real angry that we weren't allowed to do that."

Northern Cheyenne women also offered interpretations of men's psychological experiences, echoing themes from men's own accounts but also emphasizing how male patterns of thinking and behavior have affected women. Jackie, a Recovery Center client, constructed a psychological portrait of declining male and rising female social roles and responsibilities that she linked to colonialism's disproportionate impact on men's social roles and cultural practices:

> I think that women can't depend on nobody else, so they got to do it themselves. There were a lot of men I admired [in my grandparents' generation], but now ... Men today, they don't have no education, no ability to quit drinking, no self-esteem inside–they can't say "hey, I'm going to go do this" and then do it. They have false pride, they don't have that being proud of yourself as an Indian. You got to earn the right to be the men that they used to be a long time ago. They lost all that; it's gone. They don't have nobody to look up to any more. I think men are more sensitive that way. Women can keep going, with how they were raised as a child–what they learned from their parents or grandparents.

Here Jackie depicts women as more stable and more independent than men. Her comments also speak directly to broader local debates about changing gender roles—and especially, about the growing economic and social autonomy of women.

Public awareness of women's rising involvement in paid employment, educational opportunities, and positions of political leadership was widespread on the reservation by the period of Prussing's study, but considerable debate surrounded women's efforts to exert social authority as a result.

Community responses to women's visible leadership in sobriety, and specifically their greater involvement in Recovery Center services and sponsored activities, were often shaped by this broader field of controversy, which in turn tapped into even wider-ranging local debates about the meanings of tradition and change. Gus described women's leadership in recovery in terms of continuities with their social roles as caregivers in families, and called for men to move beyond the "old way" of reckoning gender roles:

> I see the women as making recovery as strong as it is in the community, because they wanted change. They took care of the families and saw that it was needed. Some men still think the old way, that women shouldn't be taking charge of their own lives–that they should stay at home while the men work.

Gus validates women's activities here but acknowledges negative responses from other men that Prussing also perceived in her community-based fieldwork.

These findings demonstrate how local cultural constructions of gender roles can shape the appeal of particular therapeutic approaches for alcohol problems in Native American communities, including the self-expressive forms of talk that are emphasized within many programs for substance abuse. They also show that community perceptions of substance abuse programs, and the therapeutic approaches emphasized within such programs, can be affected by broader commentary and debate about issues of local community concern. Considering these issues highlights how clients seeking help with alcohol problems bring these elements of their lived, daily cultural context with them as they engage the therapeutic resources offered by local programs. From this perspective, generalized formulations of the treatment needs of "Native American women" are less realistic and constructive than assessments grounded in community-specific understandings of the role(s) that gender may play in the cultural contextualization of sobriety.

CONCLUDING THOUGHTS

The two ethnographic examples that we present here demonstrate that indigenous communities in North America can share many priorities and concerns as they develop community-based substance abuse programs but vary in the programs that they develop. In particular, women's needs, interests, and involvement in such programs can be profoundly shaped by broader local cultural ideologies of gender and debates regarding changing gender roles and relationships.

These findings have several implications for treatment—and especially, for what it means to provide culturally commensurate therapies in indigenous

communities that speak to the gender-specific needs and experiences of women. Although women at Northern Cheyenne arguably benefit as a group from how the community's central substance abuse program privileges a more "feminine" style of self-expression, individual women may or may not subscribe to these localized gender ideologies in ways that improve the appeal or accessibility of the program's services. Moreover, given the politics that surround gendered social roles in daily community life and that surround transitions from drinking to sobriety, women who use the program may actually face special challenges as their participation leads them into contested arenas of identity politics and ritual practice. Institutionalizing a wider range of therapeutic approaches seems a key need in this context, including a range of locally acceptable alternatives to the conventional forms of self-expressive talk that are privileged in Western psychotherapies.

One might wonder what a therapeutic effort would look like if it was addressed to psychosocial distress and dedicated to sidelining self-expressive talk as a primary mechanism of change. In Gone's Manitoba research, one counselor offered a tantalizing suggestion of an older "traditional" way for assisting others in distress:

> See, if I had an emotional problem, I couldn't go to my parents because I just didn't see it done. At the time, I didn't realize that it was being done in another way. For example, I remember times when I would be hurt emotionally . . . , but I couldn't tell my parents. I just couldn't find the words to describe how I felt. . . . But somehow, they knew that something was bothering me, even though I couldn't put it into words. So what [my mom] would do, . . . she would take me out in the bush. And she'd start telling me about a certain herb, even though I wasn't paying attention. . . . And then she would be walking along in the bush, and then [we] would see a little animal. . . . Then she'd tell me about this [animal]. . . . What it's for, what it does, what it eats, how it survives, and how it sustained life for another animal. . . . And she'd tell me all about these birds. Who cares? And then pretty soon, I have all this new knowledge about all these animals. I forget about my problem. . . . It made me realize that, hey, my problem's not so great. This little bird can get killed any time in a second. . . . And yeah, my problem's not as great as theirs. That's what it made me realize. . . . All this time, what she was doing was making me realize that hey, your problem's not so great. And you can work your problem out. . . . What it did [was] it put my problem in a different perspective, in a way that, hey, it's not so bad. (Tom, Counselor)

Similarly, a conversation between Prussing and a tribal health administrator at Northern Cheyenne featured an interesting story about how positive community attention and support might promote sobriety as well or better than targeted psychotherapeutic intervention. In describing a community

health program that was totally unrelated to Recovery Center, Joe told of his own efforts to support a man with obvious alcohol problems:

> He was a down and out alcoholic and wino that came there one day, and he was sitting down there—see we feed them, if they volunteer. Maybe they sweep off the lawn or if there's snow, we can feed them, and he came for that. And he waited until—he was going to wait for everybody to eat and then he would sneak in there and say "I want to volunteer." So I called him. I knew he was a ceremonial person, and I called him and I says "Stand up, come here with me." And I grabbed him by the arm and we went and stood in front of everybody that was sitting down. And I said "My friend here comes from a big family. They're wonderful people." I bragged about his family, and he was trying to get—he was very uncomfortable but I hung onto him. And I praised him, about his family, where he came from, the ceremonies that he went on. And I says, "He's going to lead us in prayer today. And I want you to hear him, he has very special prayers." And he said "I'm dressed dirty, I'm really dirty—I can't." And I said "No, come on, let's do it. I'll help you, come on." I hung onto him, and he prayed. And the next day he came back, all dressed up and sober. And he says "OK, I'm ready. Go ahead call on me again!" He says, "I didn't pray good yesterday, can you call on me again?" We took him up and he was spiffy, just clean? Oh, he did a good prayer. And the result of it—he quit drinking, he's going to college now.

Whether and how such approaches—admittedly involving talk, but not direct, dialogical, psychologically minded, self-referential talk—might be harnessed for the treatment of alcohol problems and substance abuse is beyond the scope of this article. But the fact that such alternatives are articulated within communities, and sometimes by counselors within community-based substance abuse programs themselves, serves as a testament to the culturally shaped processes through which Native people continually consider and evaluate the local "fit" of therapeutic resources for alcohol-related problems.

As Prussing's example especially demonstrates, in some communities gender can figure prominently within these processes. Native women needing support for sobriety may benefit most from programs and clinicians that recognize the layers of meaning that accompany behaviors such as drinking and behavioral transformations such as sobriety. Such transformations may be supported or challenged by key cultural conventions that structure local social roles and interactions, as well as by the political debates that may be accompanying shifting gender roles and other cultural changes in their communities. These dynamics also vary by communities, as evident in how Gone's experiences in Manitoba suggest that women may be empowered by their growing roles in local ceremonial practices, whereas Prussing (2007, 2011) has found that the localized politics surrounding gender and ritual practices can both promote women's social authority and yet also subject women to disproportionate and often difficult scrutiny.

Although gender may be a universally significant cultural category, its impact on therapeutic interventions for alcohol is clearly shaped by broader local cultural contexts. Recognizing that clients enter and leave substance abuse programs as members of complex cultural communities, and that their therapeutic transformations ideally need to include skills for thinking and acting in new ways within their local social and political environments, enriches ongoing discussions of what it means to provide "culturally competent" mental health services. The Native North American experiences that we document here further suggest that focusing on the complex and variable processes of developing community-based service programs can generate useful questions about how broader political and economic pressures inform local cultural contexts—an important level of analysis that is frequently overlooked by the heavy emphasis on clinical skills and clinician characteristics in many current efforts to promote "cultural competence" in mental health services.

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