CHAPTER 12

American-Indian Mental Health Service Delivery

Persistent Challenges and Future Prospects

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As early as the Community Mental Health Movement of the 1960s, psychologists have recognized that conventional mental health services have failed to reach a significant segment of the American population who might truly benefit from appropriate support and assistance while experiencing profound psychological distress (Albee, 1968). Although this observation continues to characterize service delivery with regard to many troubled persons in today's society, it would be difficult to identify a more underserved group of people than this country's small population of American Indians and Alaskan Natives (Nelson, McCoy, Stetter, & Vanderwagen, 1992). The cultural, political, and economic isolation of Native Americans from adequate mental health services is even more remarkable when one considers that the federal government is legally and morally obligated to provide such services, given the unique political status of tribal groups in their historic government-to-government relationship with the United States (LaFromboise, 1988; Pevar, 1992). This chapter reviews the principal challenges confronting mental health researchers, professionals, and policymakers as they seek to most effectively address the mental health needs of American Indians before suggesting alternatives to conventional mental health service delivery. It is the firm conviction that Native American people deserve fully accessible, culturally appropriate, and demonstrably effective mental health services during times of psychological distress that motivates this chapter's commitment to re-envisioning mental health service delivery in American-Indian communities.

THE INSTITUTIONAL CONTEXTS OF MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

Any valid assessment of the status of mental health services for Native American communities must begin with a basic understanding of tribal sovereignty and the U.S.

federal Trust Responsibility, which provides the requisite political and legal contexts for re-envisioning Indian mental health service delivery.

Tribal Nations

The United States currently maintains government-to-government relationships with some 560 federally recognized tribes of American Indians or Alaska Natives. These tribal groups are the surviving remnants of a pre-Columbian U.S. indigenous population of over 5 million individuals comprising over 400 cultures prior to the American colonial holocaust (which reduced the population to just 250,000 by the close of the 19th century). Even today, the cultural diversity of Native America renders virtually any generalization about American Indians problematic. What most Native Americans do share in common, however, is the legacy of European-American colonization. Owing primarily to a history of treaty-making with the United States prior to 1871, contemporary tribal communities are recognized by the federal government as "domestic, dependent nations" that exercise congressionally limited powers of sovereignty attendant to this status. Moreover, Congress maintains a "general trust relationship" with these federally recognized tribal nations, which is "marked by peculiar and cardinal distinctions which exist nowhere else" in Western jurisprudence, according to the Supreme Court. This trust responsibility "resembles that of a ward to his guardian" and implies a federal "duty of protection." History routinely attests, however, to the failure of the United States to fulfill this obligation of trust and protection to tribal nations. (See Pevar, 1992, for a thorough and accessible overview of federal Indian law and practice.)

The most recent U.S. census (U.S. Census Bureau, 2002) determined that 2.5 million Americans identified solely as American Indian or Alaska Native, with an additional 1.6 million identifying as multiracial with Native American ancestry. Taken together, these individuals comprise 1.5% of the population of the United States. Census identification trends over the past few decades indicate that more Americans are choosing to identify as American Indian or Alaska Native over time because birth rates alone cannot possibly account for the astonishing growth in the self-identified population during this period. Thus, one of the dilemmas confronting American Indian mental health researchers is simply determining who in fact is an Indian for the purposes of their investigations. Inasmuch as American-Indian identity attributions are both complex and contested (Gone, in press), easily confounding the range of simplistic (usually essentialist) conceptual strategies, any particular approach to defining "Indianness" is vulnerable to critique or complaint. Nevertheless, for this chapter, an American Indian or Alaska Native is simply defined as an enrolled member (or "citizen") of a federally recognized tribal nation.

There are many reasons for privileging citizenship as the definitive criterion over self-identified race or ethnicity, degree of ancestry (conventionally measured by "blood quantum"), or cultural affinity or practice, but the single most important reason here pertains to the context in which mental health services are routinely provided to Indian people, namely through the federal programs provided on behalf of tribal nations and their citizens in fulfillment of the federal Trust Responsibility. Thus, in contrast to

the 2.5 million Americans who self-identified solely as American Indian or Alaska Native in the most recent U.S. census, this chapter will instead considers the 1.4 million enrolled members of federally recognized tribal nations as the population of Native Americans of interest owing to the significance of the federal services context for the discussion to follow. Once again, however, it is crucial to note that this conservative strategy for defining "Indianness" overlooks many categories of people who might legitimately lay claim to viable American-Indian identities.

The kind, quality, and number of federal governmental institutions and programs that most American-Indian people—especially those residing on reservations—encounter on a daily basis are difficult to adequately convey to mainstream Americans. Fortunately, during the Nixon administration Congress passed Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1975. This law sought:

> To respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities.

As a result, modern tribal governments wield substantial influence in their dealings with federal agencies and can even "contract" to directly administer federal programs and services to their own communities using the same federal dollars that would otherwise sustain the programmatic activities of the relevant agency.

The purpose of describing the government-to-government relationship in such detail is twofold. First, it affords the unfamiliar reader with some semblance of the scope and complexity of Indian affairs in the United States. Whether codified in federal law, established through bureaucratic policy, sustained by national moral and ethical obligation, or exacted by modern, politically savvy tribal leaders, the state apparatus designed to regulate and control, support and protect Native Americans—just 1% of the population of the United States—is monolithic. Most important, this distinctively American colonial legacy yields a notion of "Indianness" as not merely another race, ethnicity, or subculture, but instead as an utterly unique *political* status afforded to citizens of tribal nations that traces its origins to the Commerce and Treaty clauses of the U.S. Constitution.

Second, this review illuminates the degree to which government intrusion and control has shaped American-Indian lives historically and renders contemporary reactions of cynicism and suspicion within Indian communities toward such involvement intelligible. That is, the long colonial history endured by American Indians and Alaska Natives has profound psychological consequences for both individuals and their communities, ranging from the idiosyncratic fear and hatred of European-Americans in some instances to a more general (often desperate) pursuit of postcolonial alternatives for grounding personal and communal meaning-making. It is this latter, nearly frantic search for a viable postcolonial source of coherence, connectedness, and continuity that renders the colonial legacy utterly inextricable from contemporary concerns about American-Indian mental health.

The Indian Health Service

Within the federal services context, the principal health care organization entrusted with providing health and mental health services to the enrolled members of federally recognized tribes is that branch of the U.S. Public Health Service known as the Indian Health Service (IHS). Although American Indians and Alaska Natives are technically eligible for health services through the usual venues that provide health care for other Americans (e.g., state and county health clinics, Health Maintenance Organizations, or professionals in private practice), many enrolled tribal members depend primarily on the largely reservation-based IHS for a wide variety of health care services, including mental health services.

Legal Authority and Organization

As one expression of its Trust Responsibility for tribal nations, Congress passed the Snyder Act in 1921 authorizing health services for American Indians to be administered through the Bureau of Indian Affairs (or BIA). In the mid-1950s, Congress established the IHS to assume responsibility for such services. In addition to this early legislative authority, the federal obligation to provide health services to Native Americans was bolstered by Public Law 94-437, the Indian Health Care Improvement Act of 1976. In response to findings that American Indians and Alaska Natives suffered from much poorer health status than other Americans, Congress boldly declared that:

> It is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all the resources necessary to effect that policy.

Thus, the Indian Health Care Improvement Act—reauthorized three times since 1976—remains the modern legal capstone supporting federal provision of health services to Native Americans. Despite this express legal commitment to providing "all the resources necessary" to effect improved health status in tribal communities, however, the Director of the IHS recently commissioned a study that determined that recent Congressional allocations to the IHS represented just 52% of the costs of hypothetically assuring personal health services to a comparable number of federal employees (Federal Disparity Index Workgroup, 2002).

The IHS serves the enrolled members of federally recognized tribes and their descendants, currently comprising a service population (defined as eligible persons residing in geographic areas for which the IHS maintains responsibilities) estimated at 1.5 million (IHS, 2002). Employing a staff of nearly 16,000 from every conceivable health care profession with an annual appropriation of roughly $2.9 billion, the IHS is organized into 12 regional administrative units called Area Offices that are collectively overseen by a Central Office. Within these IHS regional Areas, direct health care services are typically provided by the most basic administrative unit within the IHS, the community-based Service Unit. The Service Unit may include a hospital, clinic, or health station, depending on local need and budgetary considerations, and typically administers a wide range of health programs, including primary medical care, behavioral health, substance abuse treatment, health education, injury prevention, public health nursing, and sanitation facility services. As of October, 1998, the IHS directly administered 66 Service Units, while tribal governments had "contracted" (through the Self-Determination Act) to directly administer 85 Service Units. In sum, the IHS provided health services to American Indians and Alaska Natives through 59 health centers, 44 health stations, 37 hospitals, and four school-based health centers, while tribal governments contracted to provide their own health services through 155 health centers, 76 health stations, 12 hospitals, three school-based health clinics, and 160 Alaska village clinics. In addition to these reservation-based health programs, the IHS also funded 36 urban Indian health projects (IHS, 1998–1999) for Native Americans who have relocated to large urban centers. Approximately 80% of all IHS Service Units maintain mental health (or "behavioral health") programs tasked explicitly with meeting the mental health needs of Indian country.

Indian Health Service Mental Health

The first IHS Office of Mental Health was established in 1965, with an annual appropriation of $500,000. More recently, the coordination of mental health and substance abuse services throughout Indian country has been assigned to the Mental Health Programs Branch and the Alcoholism/Substance Abuse Services Branch of the IHS. The Congressional allocations for these services appear as separate line items in the IHS budget, totaling $47 million for mental health services and $135 million for substance abuse services, respectively, during fiscal year 2002. Together, these allocations represent less than 7% of the total IHS budget this year.

Within its mental health programs specifically, IHS employs over 300 full-time staff, including more than 20 psychiatrists, 60 psychologists, and 110 social workers (J. Davis-Hueston, personal communication, June 22, 2001). Because of a hiring policy that emphasizes Indian preference, the IHS mental health staff is largely American Indian, although the most highly trained professional staff is largely European-American (with only two Indian psychiatrists and 17 Indian psychologists employed in the system). This trend among doctoral-level mental health professionals employed by the IHS no doubt reflects the fact that only 0.1% of clinically trained psychiatrists and .6% of clinically trained psychologists in the United States are American Indian or Alaska Native (West et al., 2000). In the context of these resources, the IHS anticipates providing mental health services at the annual rate of 208,000 "client contacts" (i.e., assessment or treatment sessions) during the current fiscal year. Although systematic information is difficult to obtain, anecdotal sources indicate that the majority of these client contacts involve *individual psychotherapy* spanning a range of theoretical orientations. Although psychopharmacological treatment is not uncommon either, it would appear that much of the responsibility for monitoring psychotropic medications falls to general practitioners within the service system owing to the shortage of psychiatrists. Given the estimated size of the service population, the IHS currently employs

roughly two psychiatrists and four psychologists per 100,000 population (in comparison to general U.S. rates of 14 psychiatrists and 28 psychologists per 100,000 population [see West et al., 2000]). Assuming an arbitrary three "contacts" per client annually, the IHS thus is prepared to address the mental health needs of less than 5% of the eligible Native population.

Finally, it should be noted that many American Indians and Alaska Natives journey beyond the IHS service area in pursuit of education, employment, and other opportunities. In fact, a significant proportion of the American Indian population at any given time resides in the nation's urban centers. Even though these individuals are entitled to mental health care at IHS facilities, many cannot readily access IHS treatment without traveling long distances to a nearby Service Unit (unless they happen to live in one of the exceptional metropolitan areas with an IHS urban health project). Thus, urban Indians—many of whom are impoverished and uninsured—are even less likely to obtain accessible and appropriate mental health services than their reservation kin, owing to financial constraints, transportation issues, uninformed service providers, etc. Thus, service delivery issues related specifically to urban Native American mental health needs are even more convoluted than those described in the remainder of this chapter. (See Witko, in press, for the specific issues pertaining to American Indian mental health in urban settings.)

FORMIDABLE CHALLENGES CONFRONTING MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

The obstacles to delivering appropriate, accessible, and effective mental health services for American-Indian and Alaska-Native communities are manifold and complex. This section concentrates on two especially formidable challenges that warrant closer scrutiny in this regard: (a) the infinite insufficiency of conventional mental health resources in Indian country; and (b) the inevitable cultural incongruence of conventional mental health interventions in Indian country.

Infinite Insufficiency

The first formidable challenge to delivering appropriate, accessible, and effective mental health services to American Indians represents a simple extension of a more general national quandary. The most recent, representative, and thorough national epidemiological survey of the prevalence of mental illness in America revealed that nearly half of the U.S. adult population suffered from a diagnosable mental disorder at some point in their lifetimes. More specifically, the National Comorbidity Survey (or NCS; see Kessler et al., 1994) determined that the lifetime prevalence of any *DSM-III-R* disorder was 48% in the adult population, including major depressive episodes (or clinical depression) among 17% of the population and alcohol dependence among 14% of the population. In addition, 29% of the adult population suffered from a diagnosable *DSM-III-R* disorder within the previous 12 months. Furthermore, comorbidity among mental disorders was high, in that over 50% of those reporting diagnosable distress qualified for more than one lifetime diagnosis. Most importantly, only 40% of those with a lifetime mental disorder reported ever obtaining professional treatment for their problems.

The quandary evident in these statistics is not the higher-than-expected rates of psychiatric distress afflicting much of the adult American population, but the comparison of such rates to the actual availability of qualified mental health service providers to treat them. Consider that the entirety of clinically trained (although not necessarily *clinically active*) mental health professionals in the United States (including psychiatrists, psychologists, social workers, psychiatric nurses, counselors, marriage and family therapists, psychosocial rehabilitation specialists, and school psychologists [see West et al., 2000]) totals just over 400,000 service providers for a national population of 280 million—a rate of approximately 150 mental health professionals per 100,000 population. If roughly one-third of America's citizens required mental health care in any given year (as the NCS results suggest), then each provider (ignoring the differences in professional role for the moment) would need to treat 200 clients annually—not including care provided to the same individuals by different professionals or service systems—to meet the nation's mental health needs. The implications of these comparisons are far from trivial, and have been a source of consternation for several decades as clinical researchers have noted that the production of mental health professionals (especially doctoral-level psychologists and psychiatrists) is so gradual that the cadre of practicing professionals will *never* be sufficient to meet the mental health needs of the nation (Albee, 1968).

As one extrapolates these realities to American-Indian and Alaska-Native communities, there can be little question that the disparity between needs and resources in Indian mental health is even more alarming. With regard to Indian mental health needs, compelling data are unusually difficult to obtain owing to the relatively small population and its wide geographic dispersion. Nevertheless, it seems indisputable that American Indians and Alaska Natives are poorer and less healthy than the U.S. population at large, with evident implications for their mental health status. According to the U.S. Census Bureau (2001), the median household income (averaged over 1998 to 2000 to allow for greater statistical stability) for Native Americans was less than $32,000, in comparison to $45,500 for White Americans, and the poverty rate was over 25% in comparison to less than 8% for White Americans. Native people die from alcoholism (627% greater), tuberculosis (533% greater), diabetes (249% greater), accidents (204% greater), suicide (72% greater), pneumonia and influenza (71% greater), and homicide (63% greater) at much higher rates than the U.S. "all races" population (Indian Health Service, 1998–1999). Finally, Indians are much less likely to maintain health insurance coverage (23% uninsured) than White Americans (14% uninsured), and are thus less likely to afford quality health care in times of need (Brown, Ojeda, Wyn, & Levan, 2000).

Unfortunately, there are no published studies of psychiatric epidemiology in Native communities that even begin to approximate the sophistication and rigor of the National Comorbidity Survey (Kessler et al., 1994)—the existing community-based studies

(Roy, Choudhuri, & Irvine, 1970; Sampath, 1974; Shore, Kinzie, Pattison, & Hampson, 1973) relied upon unconventional methodologies or outdated measures. Nevertheless, these studies collectively suggest that the prevalence of psychiatric distress—especially substance dependence and mood disorders—are unusually high in these Native communities (but see O'Nell, 1989, for a review and critique). In a report to the Senate Select Committee on Indian Affairs, Congress' Office of Technology Assessment (1990) reported that American-Indian adolescents were more likely to encounter problems related to developmental disability, depression, suicide, anxiety, alcohol and drug abuse, poor self-esteem and alienation, running away from home, leaving school prematurely, and possibly posttraumatic stress disorder in comparison to non-Indian adolescents. The trends in these studies clearly support the conventional wisdom among IHS mental health professionals that American-Indian and Alaska-Native communities generally experience higher rates of distress than their mainstream counterparts. Nevertheless, mental health researchers are persistent in their call for more sophisticated, rigorous, and culturally appropriate studies to provide more conclusive information regarding mental health status within Native communities.

For now, the best available evidence reveals a key tension in Indian mental health, with overwhelming community need on the one hand and a limited professional base within these communities on the other. More specifically, if mental health experts are willing to stipulate that conventional mental health services are essential for the effective and humane treatment of distress in American-Indian and Alaska-Native lives, then it follows that the anticipated production of mental health professionals (especially at the doctoral level) who serve these communities, when compared to the evident levels of distress that confront them there, is so discordant that it recommends despair. This infinite insufficiency of mental health resources in Indian country gives rise to an important question: Given that available resources will never be adequate to meet the needs of Indian communities under existing mental health service delivery conventions, how might researchers, practitioners, and policymakers effectively cultivate and multiply these limited resources such that they become more widely available for meeting the vast mental health needs of Indian country?

Inevitable Cultural Incongruence

There can be no question that the long search by mental health researchers for effective psychological therapies, treatments, and interventions has generated a variety of techniques that are clinically proven to reduce psychological suffering, impairment, and distress in the lives of individuals struggling with "mental illness" (see, e.g., Chambless & Ollendick, 2001). In fact, mental health professionals now command an arsenal of empirically supported treatments specifically developed to assist people suffering from nearly every major category of disorder classified in the *DSM*. Nevertheless, there is not a single, rigorously controlled outcome study that has assessed the efficacy and/or effectiveness of a conventional psychological intervention with American-Indian and Alaska-Native clients. It remains an empirical question, then, as to whether—and under what conditions—state-of-the-art mental health interventions are likely to benefit Native persons in distress. In the absence of valid scientific data, professional claims regarding the effects of conventional mental health treatments for American-Indian clients or patients remain highly speculative. Therefore, I must leave the question of whether established interventions are effective and efficacious with Indian people to the realm of empirical investigation. But there are clear reasons to suspect that conventional psychological interventions might be detrimental to American-Indian "mental health" *even if* they could be proven to reduce symptoms and improve functioning for particular individuals, owing to the thorny postcolonial context in which American mental health professionals find themselves vis-à-vis Native people. More specifically, the history of European-American colonization renders the provision of conventional mental health interventions to Native people a potentially detrimental encounter, resulting from the inevitable cultural incongruence of such interventions with the extant cultural traditions of many tribal nations.

Cultural contradictions emerge at more fundamental levels than the relatively superficial (albeit deeply significant) characteristics of various intervention technologies, of course. For example, there is an evident epistemological divergence insofar as psychology as an academic discipline is grounded in Western ways of knowing. That is, psychologists routinely adopt methodological conventions premised on a hypothetical-deductive framework (the unlikely synthesis of Western rationalist and empiricist traditions) for testing hypotheses about psychological phenomena. In principle, the theoretical viability of disciplinary constructs depends upon the foundation of evidence mustered to their support. Nevertheless, especially in professional psychology, ideas and concepts that in some cases are simply not amenable to scientific inquiry can retain widespread influence. Consider the Freudian legacy of the tripartite mind, defense mechanisms, or the role of unconscious emotion in the etiology of psychopathology that shapes both public and professional discourse on human psychology in the West despite its inherent unsuitability for scientific refutation. The point here is simply that these influential (albeit often untested and untestable) concepts, models, and orientations comprise a Western ethnopsychology with all manner of implications for the construction of Western minds, selves, and persons, as well as the pathologies that afflict them and the interventions that heal them. And the problem here is simply that these influential Western ethnopsychologies—which quite naturally inhabit conventional mental health practices owing to the latter's Western origins—are discordant with most tribal ethnopsychologies with regard to emotional experience and expression; norms governing kinds and qualities of acceptable communication; the nature of distress, disorder, and its treatment; and the meanings of personhood, social relations, and spirituality.

In the context of cross-cultural mental health service delivery, then, the dominant treatment paradigms typically employed by mental health practitioners are suffused with concepts and categories, principles, and practices that are culturally alien to most indigenous ways of being in the world. For example, Western ethnopsychologies of the person typically embrace the traditions of dualism, individualism, and modernity, conceptually separating mind from body, prioritizing the individual self over social relationships, and often excluding attention to spirituality. One implication of these

deep cultural assumptions is the organizational segregation of "mental health" from the rest of biomedicine within Western health care systems. In contrast, most Native cultures conceptualize the person in holistic terms without fragmenting selves into physical, mental, and spiritual components. Furthermore, most illness is understood in Native cultures to result from disrupted spiritual and social relationships. Finally, and most importantly, healing in Native communities is modally understood to require access to sacred power. (For a more detailed review of such cultural contrasts, see Trimble, Manson, Dinges, & Medicine, 1984.) And yet, the Western cultural assumptions exported through conventional psychotherapeutic practices are not merely mundane ideological alternatives—instead, they emerged historically in the context of a brutal U.S. colonialism. Thus, any particular instance of an American-Indian client or patient seeking assistance from a Western mental health professional is inherently shaped by a colonial tradition of power relationships, the troubling implications of which have been widely unexamined within mental health research.

Given the inevitable cultural incongruities of Western mental health interventions with American-Indian and Alaska-Native ethnopsychologies in the historical context of U.S. conquest and colonialism, the disturbing possibility arises that conventional mental health practices may actively undermine the stated commitment of most contemporary tribal communities to cultural preservation and revitalization by surreptitiously displacing key facets of the local ethnopsychology with those of Western ethnopsychology. Thus, it would seem that providers of conventional mental health services must directly confront the distinct possibility that their therapeutic practices represent a nearly invisible (but ongoing) "cultural proselytization" of distressed Native clients in their most vulnerable hour. Based on this potential for subtle cultural proselytization (which follows, of course, from the inevitable cultural incongruence of conventional mental health services in Indian country), I suggest that embracing and disseminating Western mental health concepts in Native communities—particularly when there is no compelling empirical reason to do so—is not only counterproductive to cultural preservation and reproduction but also a clear extension of European-American ideological hegemony.

In one sense, then, this volume's concern with resistance to multiculturalism in mental health service delivery is somewhat ironic, for it is the mental health professional as credentialed therapeutic expert—even when explicitly dedicated to cross-racial sensitivity and multicultural competency—who typically manages to "resist" the unsettling cultural implications of the deep Western ethnopsychological foundation on which the "talking cure" born in Vienna over a century ago ultimately rests. Even as American-Indian and Alaska-Native mental health professionals—having invested a great deal of time, energy, and money in our own training—we are reluctant to consider the neocolonial ramifications of our conventional practices within Native communities. In fact, when Indian psychologists actively resist the conventions of our training, we are most likely to disparage and dismiss the scientific foundations of disciplinary psychology while retaining a vast collection of concepts, categories, and practices that supposedly depend on scientific validation for their legitimacy. In any case, such ironies point to a second key tension in Indian mental health, with the

promise of empirically supported interventions on the one hand and the dangers of Western cultural imperialism on the other. This inevitable cultural incongruence of professional mental health practices with extant Native cultural tradition gives rise to a second important question: Given that even our empirically supported treatments have not been assessed with Indian people and depend on Western ethnopsychological theories of self, mind, and personhood, how might researchers, practitioners, and policymakers develop and assess interventions for Native communities that are culturally appropriate, demonstrably effective, and "empowering" in the American postcolonial context?

RE-ENVISIONING MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

This, then, is the crucible of mental health service delivery in American-Indian and Alaska-Native communities: The mental health needs of Indian country require a great deal more of the kinds of professional services that do not yet exist. That is, the infinite insufficiency of mental health resources in Indian country requires that mental health researchers, professionals, and policymakers find innovative opportunities to cultivate underdeveloped resources in Native communities that will promote wellness and prevent dysfunction with much greater efficiency than established professional conventions currently afford. In addition, the inevitable cultural incongruence of Western clinical interventions (and their implicit Western ethnopsychology) with extant tribal traditions requires that mental health researchers, professionals, and policymakers sponsor innovative efforts to construct culturally local alternatives to the more conventional and familiar helping services. Finally, any call to innovation in the absence of an explicit commitment to systematic outcome assessment serves no one—the measured application of scientific methodology ensures that associated claims are disciplined by the evidence at hand. Taken together, these commitments provide the impetus for re-envisioning therapeutic intervention in American-Indian and Alaska-Native communities.

CULTIVATING UNDERDEVELOPED RESOURCES

Having observed that Indian country requires a great deal more of the kinds of mental health services that do not yet exist, I should quickly clarify that the lack of appropriate services in no way implies the lack of a well-established means of developing them. With specific regard to the project of cultivating underdeveloped helping resources in Native communities, the enduring legacy of *community psychology* affords a sophisticated approach to undertaking innovation of the kind required in Indian country. Established in the 1960s as a critical alternative to conventional clinical psychology, community psychology (Rappaport, 1977) has sought to integrate its professional commitments to human resource development, progressive political activity, and rigorous psychological science in the context of a paradigm that explicitly embraces

cultural relativity, diversity, and ecology. With regard to the conventions of mental health service delivery, community psychologists have long advocated for community-based education and consultation (as opposed to clinic-based psychotherapeutic services) emphasizing collaborative and empowering relationships (as opposed to expert–client relationships) toward the development of strengths-focused (as opposed to deficit-focused) preventive (as opposed to rehabilitative) interventions. (See Rappaport & Seidman, 1983, for a thorough overview.)

The relevance of community psychology for helping to resolve the crucible of Indian mental health service delivery by cultivating underdeveloped resources depends on three closely related strategies. The first strategy promoted by community psychologists involves the reconfiguration of the professional psychologist's role beyond the provision of extended individual psychotherapy in community-based service systems. In support of this vision, community psychologists cite an extensive scientific literature that has thus far remained unable to link doctoral training and experience with enhanced psychotherapeutic outcomes despite 25 years of investigation into the matter. (See Christensen & Jacobson, 1994, for a recent review.) Such provocative scientific findings, combined with the serious economic burden of supporting individual psychotherapy by doctoral-level practitioners (i.e., psychologists and psychiatrists) within the context of an underfunded health care system, raises the question of whether the doctoral-level psychotherapist should retain any role whatsoever within American-Indian mental health service delivery settings. In fact, these findings suggest that in order to most efficiently sustain and extend the existing helping resources within American-Indian or Alaska-Native communities, doctoral-level psychologists in particular (since psychiatrists in Indian country already forego extended psychotherapy) must assume new professional roles. Instead of the direct delivery of conventional mental health services, then, psychologists must be prepared to engage in creative administration, program development, outcome evaluation, research, grant writing, training, and supervision. That is, the professional psychologists serving Native communities most effectively act as creators and facilitators of service systems oriented toward both the cultivation of helping resources already present within these communities as well as the procurement of new resources from outside the communities.

The second strategy promoted by community psychologists for cultivating underdeveloped helping resources involves the enlistment of a variety of nonprofessional "natural" helpers already active in the community into partnership with community-based service systems. These partnerships should furnish the professional psychologist with welcome insights into the culturally salient interventions already practiced in the community, while allowing for the reciprocal contribution of additional resources, professional legitimacy, and helpful organizational structures toward the wider availability and success of local therapeutic practices. The range of potentially valuable nonprofessional helpers presumably varies from community to community, but in general it seems useful to collaborate with recognized medicine persons and tribal healers who retain cultural authority in ritual matters. Given that wellness and healing in so many Native cultures involves appropriate relationships to spiritual beings, the participation of ritual leaders in service system outreach and activity is ideal.

Beside the obvious ceremonial leaders, however, there are undoubtedly other classes of existing natural helpers. For example, most federally recognized tribal nations contract to administer the federal Community Health Representatives (CHR) Program. This program employs and trains paraprofessional health aides who travel to the homes of the elderly and sick to deliver medications, check blood pressure or blood sugar, assist in limited home care, provide transportation to health care appointments, etc. Naturally, CHR providers regularly "counsel" those in their care by expressing empathic support or offering helpful advice. In addition, they are frequently the first to know when struggling community members encounter crisis. As a result, the CHR providers within tribal communities remain an obvious mental health resource that is largely underutilized in the sense that they receive very limited training with regard to assisting persons in psychological distress—even a very modest education and support structure within the local mental health service system could enable CHR providers to help community members cope more effectively with distress or refer community members to more experienced helpers in appropriate situations.

Additional examples of natural helpers who might substantially extend the reach of community-based service systems include tribal college students and key family members. On many reservations, tribal governments operate locally controlled community colleges that enroll a significant number of community members as students. In most tribal colleges, students pursue associate's degrees in vocational curricula such as Human Services. Such students might benefit substantially from structured Human Services practica that could be coordinated jointly by the tribal college and the mental health service system. Indeed, the establishment of a college-based Mental Health Worker's Program could provide a regular supply of talented and energetic community members available to staff a crisis hotline or run a youth prevention program in exchange not for scarce financial resources but for course credit toward their degrees. Beyond tribal college students, certain key members of large extended family networks—often respected elders—already serve as helping resources in Native communities for others to turn to in times of crisis or distress. Such natural helpers routinely advise, counsel, and support their relatives in accordance with tribal kinship traditions, but may nevertheless encounter occasional situations (e.g., a suicidal family member) in which they become overwhelmed by dire circumstance. Informal partnerships between the mental health service system and such helpers may ensure that these resourceful individuals obtain the knowledge, skills, and support to more effectively serve their families in times of need.

A final strategy promoted by community psychologists for cultivating underdeveloped helping resources involves the professional facilitation and support of community-based self-help programs. Once again, a fledgling scientific literature has begun to attest to the therapeutic power of self-help efforts (Gould & Clum, 1993). These kinds of interventions represent one approach to extending the availability of therapeutic resources in the context of a community-based service system. More familiar to mental health professionals in Indian country, however, are the 12-step groups such as Alcoholics Anonymous (AA). Although the philosophy and values of groups like AA distinguish them from professional service delivery in key ways, there can be no question

that professional encouragement and support of such groups remains a cost-effective way to multiply the helping resources available to struggling community members. Additionally, many Native communities welcome and celebrate various Christian practices that resemble self-help. For example, several northern Plains tribal communities with long histories of Catholic missionary involvement participate in the Cursillo movement in which adherents gather for emotionally and spiritually intense weekend retreats for cleansing and renewal. Finally, it should be clear that traditional participation in Native ceremonies represents an additional healing resource that might benefit from professional referral and support in the context of a service system's commitment to extending help as widely as possible within the community.

Nevertheless, merely extending the reach of helping services within American-Indian and Alaska Native communities in and of itself is no solution to the crucible of American-Indian mental health service delivery unless such efforts take seriously the call to construct alternative helping interventions that overcome the dangers of subtle Western cultural proselytization in the guise of aiding those in distress.

Constructing Alternative Interventions

The strategies described in the preceding undoubtedly assist the mental health professional in offering a great deal more to Native communities, but before acceptable progress can be made the development of services that do not yet exist is required. The process of actively constructing appropriate alternative interventions depends first and foremost on the systematic exploration of the cultural foundations of such interventions. More specifically, the first stage of program development in Native communities requires the formulation of a reasonably sophisticated ethnopsychology in order to ensure that newly created interventions avoid reproducing the colonial legacy. Such exploration will undoubtedly proceed in interdisciplinary fashion insofar as scientific psychopathology (Millon, Blaney, & Davis, 1999), psychiatric anthropology (Kleinman, 1987), community psychology (Rappaport & Seidman, 2000), sociolinguistics (Hymes, 1974), and the philosophy of social science (Fiske & Shweder, 1986) bear obvious relevance. Nevertheless, the most prominent interdisciplinary tradition of interest here is the re-emerging field of cultural psychology (Shweder & Sullivan, 1993).

Cultural psychology takes as its conceptual point of departure the co-constitution of culture and mind (Shweder, 1990). Its central locus of inquiry therefore concerns the semiotic (i.e., symbolically mediated) nature of human experience, which implies several fundamental commitments. The first of these commitments is the empirical elucidation of human "psychic diversity" across cultures. A second commitment is its focus on human *action* (or cultural practice) that, in this context, implies situated and meaningful human behavior. A third commitment of cultural psychology is the privileging of interpretive methods in an effort to understand cultural meanings inherent to such action. A fourth commitment of cultural psychology is the careful analysis of discourse (or situated communicative practices). The analysis of discursive practice typically focuses on language usage as fundamental to human experience, where language is seen as the primary symbol system by which human beings construct and communicate meaning in embodied action.

The formulation of a local ethnopsychology within the framework of cultural psychology encompasses multiple relevant content areas, including culture, language, and mind; self and personhood; emotional experience and expression; concepts of health, illness, and healing; and research reflexivity (i.e., attention to how the knower constructs the known). For instance, one area of inquiry with obvious relevance for the design of mental health interventions concerns the local construction of emotion. For in marked contrast to academic psychology's reigning assumptions regarding the universality of the so-called "basic" emotions (Ekman, 1984), affect across cultures can differ markedly in terms of the interpretations ascribed to otherwise merely physiological impulses as well as in terms of the salient practices surrounding its communication to other social beings (Harre, 1986; Lutz & White, 1986). As a result, the development of truly appropriate interventions necessarily requires that professionals working in Indian country attain some form of limited competency in the conceptualization and exploration of culture in human activity. Obviously, such competency also requires expertise with interpretive methods in addition to the variable-analytic methods that are most familiar to psychologists (see, e.g., Denzin & Lincoln, 2000). Furthermore, I have already observed that effective mental health professionals in Indian country must learn to solicit the involvement of cultural experts, spiritual leaders, and natural helpers in order to develop a culturally appropriate mental health service system, recognizing that the end results of such collaboration may bear little resemblance to conventional clinical intervention. Finally, it bears restating that Native communities deserve a scientific assessment of efficacy for any new interventions developed in collaboration with local authorities.

Although examples of the kinds of alternative interventions envisioned here are unprecedented in the literature, the process of developing such interventions is rather intuitive. Recall that the ultimate goal of such programmatic efforts is to commence a collaborative, sustained, and empowering relationship with a designated tribal community whereby innovative programs designed to facilitate wellness and prevent dysfunction within the community might be developed, refined, and scientifically assessed in close consultation with local community members. Of course, the precise contours of any intervention developed collaboratively with community members are difficult to predict in advance, but the steps taken toward realizing effective alternative mental health interventions would likely include the following. First, the professional psychologist acting in her flexible role as administrator of the local service system needs to identify and engage a variety of local community members, agencies, and institutions in order to forge relationships that sustain the development, implementation, and assessment of the intervention. Second, the psychologist (or her research collaborators) need to conduct initial ethnographic work with community members in order to better understand the local cultural discourse regarding emotional and psychological health and wellness, as well as community conceptualizations of disordered experience and its treatment. Third, building on these ethnographic findings, the psychologist

determines with involved community members what the focus of the intervention should be (e.g., to promote prosocial behavior among troubled community youth, to facilitate effective support and advocacy by individuals on behalf of distressed family members, to consolidate and extend treatment/healing resources within the community, etc.). Fourth, the psychologist would consult with community members to design a specific intervention with careful attention to targeted participants, required resources, desired outcomes, and assessment methodology. Fifth, extramural funding from government agencies or private foundations should be pursued to fund the project. Sixth, the psychologist implements the intervention in close collaboration with community members. Seventh, intervention outcomes are assessed. Finally, results, revisions, and modifications to the program are disseminated in both scientific and grass roots circles. The emphasis here is thus on the development of demonstrably effective, culturally grounded interventions that directly addresses the pressing "mental health" concerns of the communities of interest.

CONCLUSION AND SUMMARY RECOMMENDATIONS

No contemporary culture exists in a vacuum, and in the postmodern era of rapid globalization, cultural transformation is inevitable and sometimes even desirable. But in the context of postcolonial America, it is essential that Native communities be afforded the opportunity to negotiate cultural transformation explicitly and on their own terms. Indeed, the dilemma posed by conventional mental health services in Indian country is not that cultural transformation might occur, but that it might occur without the explicit awareness of either tribal members or the mental health professionals who treat them. My suspicion is that the greatest opportunities for formulating and implementing culturally grounded alternative interventions lie in the arena of community psychology, which has sought over three decades now to explicitly de-emphasize the resource-intensive practice of individual psychotherapy in favor of commencing collaborative, sustained, and empowering relationships with communities of citizens (in this instance, tribal communities) whereby innovative, culturally grounded interventions may be developed, refined, and scientifically assessed in close consultation with local Native people. Such efforts will ultimately depend on the conceptual and methodological approaches of cultural psychology insofar as ascertaining the character of local ethnopsychologies is essential to the success of these endeavors. In sum, the development of such novel, community-based interventions holds the greatest promise for overcoming the crucible of American-Indian mental health service delivery.

As mental health professionals working to cultivate strategies of intervention that proactively assess and surmount the dangers of subtle "cultural proselytization" in cross-cultural contexts and encounters, four principles must guide our fledgling efforts. First, we must always keep *culture* in mind. That is, we must never forget that our professional concepts and categories, and tools and techniques are cultural products or artifacts whose mechanisms and meanings emerge from and depend upon the

cultural intelligibility of their operations to both "practitioner" and "client." As cultural artifacts, these interventions must be understood in terms of their historical origins and evolution within the West as just one example of how humans might conceptualize therapeutic intervention more broadly. Second, we must always keep culture in *mind.* That is, we must never forget that the foundations of mind, self, and personhood (i.e., the "psyche") are themselves cultural and therefore vary in remarkable ways across communities around the world. As fundamental constituents of the psyche, cultural meanings and practices must be examined as they pertain to key facets of the local ethnopsychology in order for professional helpers to proceed most appropriately. Third, we must develop, implement, and evaluate innovative, culturally appropriate interventions collaboratively. That is, the local enlistment of a variety of active healers and other "natural" helpers would afford a degree of insight into the culturally salient interventions already practiced in the community, while concurrently allowing for a joint analysis of the validity, viability, and effectiveness of novel forms of intervention in unfamiliar cultural contexts. In fact, close collaboration with community members may be the only means to determine which cultural transformations that accompany conventional techniques are welcomed in the interest of help and healing, and which are seen as undesirable or inappropriate in local cultural contexts. Finally, we must assess process and outcome more comprehensively. That is, given the kinds of innovations that result from collaborative program development, the assessment of effects—both therapeutic and countertherapeutic—throughout the course of an intervention must be both extensive and rigorous. More specifically, in addition to searching for the desired outcomes of such novel efforts, professionals must also attend more comprehensively to the miscommunications, standoffs, breakdowns, and failures in the course of implementing services because such mishaps may signify subtle and implicit incommensurabilities between therapeutic models and the local ethnopsychology.

In considering the foregoing elaboration of my commitment to re-envisioning mental health service delivery in American-Indian and Alaska-Native communities, many may quickly dismiss this approach as too idealistic in the context of the realities of mental health service delivery in the 21st-century United States. Were I constrained by the realities of conventional service delivery in the modal health care system, I would agree with such critiques. The point of reviewing the institutional context of IHS mental health service delivery in such detail, however, was to make clear that federally recognized tribal governments retain the authority under present federal law and practice to contract for local administration of services and programs using congressionally allocated federal monies. This unique right of sovereign tribal governments extends even to the assumption of control over the entire local mental health service system. Thus, the possibilities for reconfiguring such systems in direct response to the extensive mental health needs of the community are constrained only by the imaginations of tribal leaders and the expertise of the mental health professionals they employ. In short, I remain cautiously optimistic that a handful of visionary tribal governments will ultimately recognize the crucible of mental health service delivery and, in response, take measures that will actively facilitate the creation and establishment

of a great deal more of the kinds of professional mental health services that do not yet exist.

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