

Psychotherapy and Traditional Healing for American Indians: Exploring the Prospects for Therapeutic Integration Ψ

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Abstract

Multicultural advocates within professional psychology routinely call for “culturally competent” counseling interventions. Such advocates frequently cite and celebrate traditional healing practices as an important resource for developing novel integrative forms of psychotherapy that are distinctively tailored for diverse populations. Despite this interest, substantive descriptions of specific forms of traditional healing vis-à-vis psychotherapy have appeared infrequently in the psychology literature. This article explores the prospects for therapeutic integration between American Indian traditional healing and contemporary psychotherapy. Systematic elucidation of historical Gros Ventre healing tradition and Eduardo Duran’s (2006) culture-specific psychotherapy for American Indians affords nuanced comparison of distinctive therapeutic paradigms. Such comparison reveals significant convergences as well as divergences between these therapeutic traditions, rendering integration efforts and their evaluation extremely complex. Multicultural professional psychology would benefit from collaborative efforts undertaken with community partners,

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as interventions developed in this manner are most likely to effectively integrate non-Western healing traditions and modern psychotherapy.

Keywords

American Indians; cross-cultural counseling; multiculturalism; alternative medicine; traditional healing

I don't know if mom knew that [this elderly man named] Old Spotted Bird had [traditional] medicine, too, for little children. . . . [My dad] went over to him with a [tobacco-] filled pipe [to implore him to help my baby sister]. It was a very solemn thing that was happening when they take a pipe to somebody like that. . . . After smoking [this] pipe, [Old Spotted Bird] asked my dad what he could do for him. Dad said, "I pray that you can help me. I got a really sick baby." He [continued], "You know that me and my family are real pitiful because we don't have too much of these worldly goods. . . . We got some buckskin. . . . Your wife could make you some moccasins. We got a blanket. . . ." [Old Spotted Bird] said, "Oh, I'll come right over." So dad went right home.

This kid was just . . . weak. She could sit up by herself, but she was really weak. She was about a year old. Skin and bones. Really sick. . . . She didn't cry she was so sick. . . . She just sat there, little thing, just pitiful. . . . They had her sitting up facing them. . . . [Old Spotted Bird] had this medicine. . . . Just looked like ground up wild turnips. That texture. I don't know what it was. He says, "I'm going to [put this medicine in my mouth and] blow this medicine through [her chest]." He said [to my dad] . . . , "You hold this [black scarf] behind her like this. Right behind her. About that far from her." He said, "When I blow this medicine through her, it's going to hit that scarf. If it falls down, it's no use. . . . But if it sticks to that scarf, maybe then I can [help]." So . . . he blew that medicine through [her chest] and it just stuck [to the cloth] like it was wet or glued. . . . It just sprayed on that black scarf. And it just stayed [stuck] there. . . .

So . . . they laid [my sister] down. And she was just lethargic. . . . All she had on was a diaper. . . . He [put his mouth to her skin and] sucked [at different places on her body] Behind her knees and on her ankles. And right on her hips. Every time he just really sucked hard. And he just pulled his head away like that. He'd spit out this stuff. And it was white like that stuff he sprayed [through her onto the cloth]. Looked like cottage cheese. . . . He'd spit it in a

[coffee] can. He showed it to my dad. . . . When he was through [sucking], he says, "Tell your wife she has to quit nursing this baby. She's poisoning this baby, because she's already carrying [a new] one. . . ." So they weaned her. . . . She got better.

—Gros Ventre elder Bertha Snow (March 1995 interview)

Appearing in the pages of *The Counseling Psychologist* almost 20 years ago, the now classic article by LaFromboise, Trimble, and Mohatt (1990) presented the compelling case for integrating counseling interventions and American Indian traditions in service to more culturally resonant psychotherapy with Native American clients. More specifically, these authors proposed that professional psychologists working in "Indian country" undertake a set of three closely related strategies. First, they urged the facilitation of greater access for Native clients to "traditional treatments." Second, they recommended the practice of modes of psychotherapy that were more theoretically consonant with Native traditions. Finally, they promoted the integration of "traditional healing methods" with these modes of psychotherapy to ensure a progressive reconstruction of the counseling endeavor (i.e., "cultural competence"). Especially interesting was the call to *integrate* psychotherapy and traditional healing for ensuring the access, relevance, and efficacy of counseling interventions for American Indian populations. In their article, the authors mentioned sweat lodge ceremonies and peyote meetings in passing, but focused more on summary generalizations of traditional Native therapeutic activities rather than concrete examples. Had they been more descriptive, perhaps the authors would have included activities such as the healing session witnessed firsthand by my own grandmother circa 1920 (and recounted to me as above).

In the decades since publication of this seminal article, the scientific literature concerning cultural competence in professional service delivery for the "culturally different" has exploded (Sue, Zane, Hall, & Berger, 2009). For example, several articles related to this topic have appeared in the *American Psychologist* during the past 15 years (e.g., Allison, Crawford, & Echemendia, 1994; Bernal & Castro, 1994; C. C. I. Hall, 1997; Office of Ethnic Minority Affairs, 1993; Rogler, 1999; Sue, 1998, 2003; Sue & Zane, 1987). This literature seeks to tailor conventional psychotherapies for the benefit of peoples immersed in beliefs, practices, and worldviews that diverge substantially from those of the Western middle classes. It proposes that attention to the shared patterns of activity, interaction, and interpretation pertaining to the amelioration or management of distress in these communities will afford nuanced and compelling insights for practitioners (Moodley, 1999;

Vontress & Epp, 2000). Moreover, alongside LaFromboise et al. (1990), much of this literature conveys overt esteem for traditional healing as one form—perhaps the *quintessential form*—of culturally competent therapy (Atkinson, Thompson, & Grant, 1993; Constantine, Hage, Kindaichi, & Bryant, 2007). The issue then becomes how best to adopt, adapt, and approximate various aspects of these therapeutic traditions in practicable terms in the modern psychotherapeutic endeavor.

On one hand, it seems unlikely and perhaps even undesirable that doctorally trained psychologists would themselves become competent traditional healers. On the other hand, attaining cultural competence in the practice of psychotherapy with culturally diverse clients should presumably extend well beyond mere cosmetic alterations in the counseling process. Otherwise, such superficial modifications might simply mislead potential clients into participating in otherwise conventional “West-is-best” interventions. Thus, acceptable forms of culturally competent psychotherapy will necessarily involve a substantive synthesis or integration of local healing traditions and conventional psychotherapeutic practices (as originally suggested by LaFromboise et al., 1990). In the pursuit of such integrative efforts, a crucial question arises: How much “culture” is required for the culturally competent practice of psychotherapy with the culturally different? Presumably, an answer to this question will require sophisticated familiarity with both particular modalities of conventional psychotherapy as well as the epitomes of “culturally competent” intervention for any given population, namely, its local forms of traditional healing.

In exploring this crucial question, this article aspires to (a) extend the fledgling literature dedicated to the description and explication of specific forms of traditional healing and (b) trace the resultant implications for the professional project of integrating these traditions with modern psychotherapy. To achieve these objectives, five constituent tasks must be fulfilled. First, the psychological literature concerned with traditional healing vis-à-vis the practice of psychotherapy is reviewed, revealing that substantive consideration of the complexities of therapeutic integration within the discipline—especially with regard to American Indian client populations—remains in its infancy. Second, a detailed description and explication of a historical northern plains American Indian healing tradition is presented. Third, similar consideration of a modern culturally specific psychotherapy designed for American Indians follows. Fourth, in light of clear contrasts between the broader cultural contexts of American Indian traditional healing and contemporary health care services more generally, a methodical comparative analysis of these therapeutic approaches is presented. Finally, the resultant implications for integrating conventional psychotherapy and

traditional healing is discussed, including overt attention to the practical dilemmas that confront such efforts as well as the presentation of an innovative approach designed to advance research and practice in this arena.

Psychotherapy and Traditional Healing in Professional Psychology

One response to the burgeoning literature on multicultural competency within professional psychology has been to advocate for careful operationalization of constructs and subsequent empirical investigation of the relationships between culturally grounded psychotherapy approaches and associated therapeutic outcomes (G. C. N. Hall, 2001; Sue, 2003; in the context of American Indian therapeutic interventions, see J. P. Gone & Alcántara, 2007). Despite disciplinary movement in this direction, however, the call to integrate psychotherapy and traditional healing likely requires additional preliminary attention first, owing to extremely limited coverage of specific forms of traditional healing relative to psychotherapy within the psychology literature. That is, to empirically investigate therapeutic process and outcome for interventions that integrate psychotherapy and traditional healing—or, for that matter, to professionally determine how best to actually integrate these frequently divergent approaches—detailed exploration of the rationales, logics, and techniques of specific forms of traditional healing must be documented and explicated. In other words, a necessary precursor to the development of such integrative efforts (not to mention their subsequent evaluation) would seem to be publication of descriptive case studies of at least some *concrete instances* of traditional healing. The flourishing cultural competence literature notwithstanding, these studies have yet to appear in disciplinary publication venues with even minimal representation.

Published Descriptions of Traditional Healing

The results of bibliographic searches conducted in the PsycINFO database in preparation for this article bear this out. Entry of two terms (*psychotherapy* and *traditional healing*) into this searchable index in March 2008 produced 110 English-language citations. Elimination of book reviews, dissertations, and other citations obviously lacking substantive detail regarding specific forms of traditional healing (e.g., broad ethnoracial group overviews, abstract theoretical rapprochements, general explorations of culture and treatment, epidemiological descriptions of service utilization, etc.) narrowed the corpus to 60 references. This body included 18 chapters appearing in seven monographs

concerned with psychotherapy and various African healing traditions, all authored or edited by a research group in South Africa (S. N. Madu, P. K. Baguma, and A. Pritz). Published primarily by obscure African presses (e.g., UNIN Press), these sources were not generally available for review, thereby reducing the corpus of accessible citations to 42. The remaining sources included 27 citations appearing in an edited collection by Moodley and West (2005), 7 citations appearing in an edited collection by Adler and Mukherji (1995), a book concerning African ethnopsychotherapeutic practice authored by Peltzer (1995) and published in Germany, a chapter reviewing folk healing systems among U.S. ethnoracial groups by Koss-Chioino (2000), and a chapter reprint of LaFromboise et al. (1990). The number of citations returned in the form of the gold standard for publication in the discipline—namely, peer-reviewed journal articles—totaled only five citations (Moodley, 1999; Odejide, 1979; Tantam, 1993; Vontress, 1991; Vontress & Epp, 2000). Of these, only Tantam (1993) offered a description in any detail of an instance of traditional healing (two pages recounting an exorcism in Zanzibar).

These results suggest two conclusions. First, the prevalence of descriptive case studies pertaining to concrete instances of traditional healing in the extant psychological literature vis-à-vis the practice of psychotherapy is exceedingly low. This state of affairs is perhaps not surprising given the disciplinary bias toward experimental and correlational studies (Cronbach, 1957), but in the context of a flourishing multicultural literature that cites and celebrates traditional healing practices the rarity is striking. Second, the best accessible sources in psychology for obtaining descriptive information concerning distinctive practices of traditional healing relative to psychotherapy are not in fact journal articles but rather edited book collections. For example, the most comprehensive of these was the edited volume by Moodley and West (2005). These scholars were overtly critical of what they saw as the multiple failures of multicultural psychology in the West. Instead, they saw “the inclusion and integration of traditional healing methods into mainstream counseling and psychotherapy” as the only viable alternative to these failures (p. xvii). Their book canvasses a wide range of healing practices in 27 diverse chapters authored by 30 international contributors devoted to characterizing specific approaches and techniques, including assessment of their prospects for incorporation into or augmentation of psychotherapy. The breadth of healing traditions portrayed is the obvious strength of this work, but at roughly a dozen pages per chapter, substantive attention to the “fantasies, complexities, and confusions that surround the adoption” of traditional healing awaits additional treatment (p. xviii).

Perhaps the best of these edited collections did not appear in the PsycINFO results pertaining to psychotherapy and traditional healing at all. Gielen, Fish, and Draguns (2004) published their handbook on culture, healing, and psychotherapy as a more comprehensive entry into the literature pertaining to fundamental issues in the cross-cultural comparison of therapeutic traditions around the world. Twenty-six authors contributed 20 chapters concerning the relationship of culture and illness, the multicultural movement within North American therapeutic service delivery, and the diversity of therapeutic traditions from the Americas, Asia, and Africa, respectively. Moreover, Gielen et al. included an impressive bibliography of source materials as an appendix. In their measured introduction to the volume, Draguns, Gielen, and Fish (2004) surveyed the many challenging questions that arise from such considerations: "What is the relative weight of culture in determining the effectiveness of psychotherapy, its conduct, and its style? What specific cultural dimensions matter in psychotherapy, in what way, and to what extent?" Relative to the integration of modern psychotherapy and traditional healing specifically, they asked, "How can traditional and modern therapies be creatively combined and integrated in their application to underserved and isolated cultural groups?" Although these authors allowed that subsequent chapters addressed at least some of their questions, Draguns et al. remained modest in their self-appraisal: "Most of [these questions] are many steps removed from a definitive, empirically based resolution. Collectively, these questions may guide the field for decades to come" (p. 3).

American Indian Traditional Healing

With regard to American Indians specifically, J. P. Gone and Alcántara (2006) reviewed the literature pertaining to traditional healing in an unpublished report concerned with suicide prevention in this population. After casting a large bibliographic net across four databases in the social and health sciences (including PsycINFO), 68 articles and chapters were classified for purposes of broad contextualization and discussion. The most relevant literature included Jilek (1974), Milne and Howard (2000), Mohatt and Varvin (1998), and Storck, Csordas, and Strauss (2000). Each of these articles described tribally distinctive healing practices in some detail (often with reference to case studies in which these activities were impressionistically understood to have positively impacted the mental health status of particular community members). They did so, however, *outside of the context of psychotherapy proper* and in only ancillary fashion to health care programs and services. Additional discussion of traditional healing as complementary to formal

counseling intervention was offered by Atneave (1974), Bergman (1973), Kahn, Lejero, Antone, Francisco, and Manuel (1988), Meketon (1983), and Mohatt (1988), all of whom referenced collaborations between American Indian traditional healers and mental health professionals in the context of health care services. None of these citations provided explicit details about the nature of the included healing activities, evaluation of healing-related therapeutic outcomes, or the bureaucratic arrangements through which healers were incorporated programmatically.

Scurfield (1995) offered perhaps the best description of any such collaboration in the context of a Veteran's Administration-supported posttraumatic stress disorder treatment program that included culture specific additions in the form of sweat lodge ceremonies and powwow participation. It remains debatable, of course, whether the sweat lodge and powwow qualify as traditional healing *per se*. Scurfield did not explicitly characterize the sweat lodge component of the program as "traditional healing" and referred to knowledgeable Native consultants as "spiritual leaders" rather than "traditional healers." Beyond this, additional literature testified to the cultural dilemmas raised by certain kinds of traditional healing *vis-à-vis* professional service delivery. For example, Navajo healing ceremonies for epileptic seizures, grounded in local beliefs that such illness was the proper consequence of immoral sexual behavior, were judged ineffective at best and possibly even harmful for afflicted patients by outside researchers (Levy, Neutra, & Parker, 1979). Along with many contemporary health professionals, these researchers categorically rejected the Navajo belief that epilepsy is caused by sibling incest. Moreover, in Mohatt and Varvin's (1998) cultural formulation case study, their Lakota client actually experienced a relapse of psychotic symptoms requiring acute crisis management following her participation in traditional activities. Of course, the significance of this client's relapse in the face of ceremonial intervention remains a matter of interpretation.

Despite this body of cursorily related scholarship, it is important to recognize what J. P. Gone and Alcántara (2006) could *not* find in the literature pertaining to American Indian traditional healing and suicide prevention. The authors could not identify through their bibliographic searches any Native suicide prevention efforts that explicitly incorporated traditional healing practices within their program activities. They could not identify through their searches even one careful description—including details such as referral mechanisms, diagnostic practices, ritual descriptions, compensation schedules, outcome evaluations, and so forth—of the kinds of collaboration between traditional healers and reservation health care systems that have been observed or recommended in published commentaries for decades (see

Atneave, 1974; Torrey, 1970). They could not identify through their searches even a single instance of a controlled outcome assessment for a specific form of Native American traditional healing administered to some subset of patients for a clearly designated problem. To the degree that American Indian traditional healing might find greater understanding, acceptance, and even legitimacy in health care research, policy, and practice through inclusion in the scientific literature, J. P. Gone and Alcántara concluded that additional research (whether variable-analytic or interpretive) would seem to be imperative.

Toward Comparative Examination

One apparent means to clarifying the prospects and pitfalls of therapeutic integration efforts would seem to be comparative examination of concrete practices of traditional healing on one hand and culturally specific psychotherapy on the other for the same distinctive community of interest. This exercise should be even more illuminating if the psychotherapy in question is one that overtly integrates facets of traditional healing to maximize its cultural relevance. Clearly, this ambitious task will necessitate taking advantage of the unusual opportunity provided by *The Counseling Psychologist* for more extensive coverage and elaboration; undoubtedly, limited space requirements in the usual disciplinary publication outlets have restricted previous inquiry of this sort.

Sources of therapeutic data. The detailed comparison of traditional healing and culturally specific psychotherapy offered in this article pertains specifically to a northern plains American Indian people, the Gros Ventres of the Fort Belknap Indian reservation in north-central Montana. Empirical description and explication of traditional healing activities in American Indian communities—especially in the wake of a repressive Euro-American colonization—are fraught with ethical challenges. First, ritual healing practices in Native communities—alongside other indigenous ceremonial activities—were actively suppressed by government and church officials for much of the 20th century. The full and free practice of such traditions was not affirmed in the United States until Congress passed the joint resolution known as the American Indian Religious Freedom Act in 1978 (Pevar, 2004). By then, of course, traditional healing had been completely eradicated from many tribal communities. Second, for those tribal communities that have retained and reclaimed ritual healing practices, there remains great sensitivity toward outsider observation, formal description, and published explication of specific instances of ceremonial ministrations. This is in part from the legacy of

colonial injury and in part from wanton appropriation and commercialization by New Age adherents and other “wannabes” (Jenkins, 2004). As a result, most contemporary Native people would be aghast at the idea of recording ceremonial activities in any detail for research purposes. Among professional psychologists, Mohatt (1988; see also Mohatt & Eagle Elk, 2000) has probably ventured as far as one can responsibly proceed in this regard. Finally, in the context of substantial colonial disruptions, it should not be surprising that many healing traditions have evolved remarkably during the past century. Even in tribal communities that recognize contemporary medicine people, for example, it would be unusual to encounter an old-time “sucking” doctor such as Old Spotted Bird from this article’s introductory vignette. As a consequence of these challenges, the “data” for exploring the rationales, logics, and techniques of Gros Ventre healing tradition are drawn from an extended historical narrative concerning the life and times of a famous tribal healer (or “medicine man”).

Written by the author’s great grandfather, this narrative was later published under the editorship of a second tribal member (F. P. Gone, 1980). Despite the limitations that inhere in any mediated account of ritual healing, adoption of this narrative has the advantage of circumventing the challenges just described while affording insight into historical Gros Ventre healing practices that were completely decimated as a consequence of a brutal colonial encounter. At the outset, however, it is crucial to address questions regarding the accuracy and representativeness of the account relative to historical Gros Ventre healing practices more generally. First, the accuracy of the healing activities described in the narrative must be contextualized within the genealogy of the narrative itself. This genealogy has been described in detail elsewhere (J. P. Gone, 2006a), with particular emphasis on the culturally salient commitment of the parties involved in its reproduction to *fidelity* in the preservation of an authoritative oral tradition. More specifically, in the passing down of this life narrative, “Each of these . . . mediated redeployments [of the narrative] was characterized by overt concern for truth, accuracy, and faithfulness” (p. 82). Such fidelity was evidenced by explicit avowals that narrative events were recounted without error or elaboration as well as exhaustive inclusion of complex ritual details that would seem to defy narrative interpolation in the absence of clear memory. Second, the representativeness of the healing activities described in the narrative must be contextualized within the extant anthropological record concerning Gros Ventre ritual healing. In this regard, Cooper (1957) devoted more than 50 pages to the elucidation of Gros Ventre “curing practices” in which the ritual activities and associated logics described in his survey clearly reinforce the

representativeness of the specific healing encounter reviewed in this article as an exemplary instance of a conventional, intelligible, and familiar cultural formation.

Similarly, owing to both the ethical and logistical challenges of observing and recording instances of the particular counseling intervention in question, the “data” for analyzing Eduardo Duran’s (2006) “soul wound” psychotherapy are drawn from the detailed session material reproduced in his book. While these data have no doubt been selectively vetted by Duran for published presentation, they retain the advantage of best exemplifying what the author himself envisioned for an explicitly integrative, culturally competent approach to counseling American Indian clients. As a result, they afford a generous opportunity for comparison. Finally, given the broadly targeted client base for Duran’s soul wound psychotherapy (i.e., all indigenous peoples), it is worth noting that perhaps any number of American Indian healing traditions might have been selected for this comparison. As a Gros Ventre tribal member who is formally trained in professional psychology, however, the author has maintained longstanding interest in explicating these particular cultural traditions for a broader disciplinary audience (J. P. Gone, 1999, 2004a, 2004b, 2006a, 2006b, 2006c, 2007, 2008e, in press; J. P. Gone & Alcántara, in press; J. P. Gone, Miller, & Rappaport, 1999).

Appropriateness of therapeutic comparison. Prior to embarking on analyses of these data for comparative purposes, however, the relative comparability of the two paradigms requires an important clarification. More specifically, it is expected that researchers and practitioners of psychotherapy might point to a crucial distinction between Bull Lodge’s ritual performance and Duran’s psychotherapeutic intervention with regard to their mutual equivalence. More specifically, Bull Lodge is seen to have “doctored” a relative for an unspecified “physical” illness, whereas in contrast Duran (and other psychotherapists) typically treat psychological expressions of disorder. With regard to this distinction, three observations seem relevant. First, the distinction between so-called “mental” health and so-called “physical” health would appear to reflect longstanding traditions of mind–body dualism in Western health care (Miresco & Kirmayer, 2006). Although Gros Ventres would certainly have recognized the difference between infirmities of the body and mental derangement, there is no ethnological evidence that this people made historical distinctions between psychological distress and physical illness in any elaborated manner, suggesting that this now rampant dichotomy is Western in origin. This fact would thus seem to preclude more direct comparisons involving the ritual healing of psychological suffering per se.

Second, Gros Ventres prized endurance, tenacity, and forbearance in personal character to such a degree that the pursuit of specialized therapeutic

attention for psychological distress alone must have seemed beyond comprehension (Flannery, 1953; Fowler, 1987; J. P. Gone, 2004a; J. P. Gone & Alcántara, in press). At the same time, some anthropologists have proposed that many of the illnesses so effectively treated by medicine persons and indigenous healers in non-Western societies may have been somaticized forms of relational or interpersonal distress (Kleinman & Sung, 1979; Murdock, 1980). Finally, even in cases involving mental derangement among the Gros Ventres, etiology would have been understood to involve mechanisms similar to that of other forms of somatic illness (e.g., object intrusion by a malevolent spirit; see Cooper, 1957). In all such cases, consultation with medicine persons would have been an intelligible and appropriate course of action. As will become increasingly evident, these considerations alone suggest important cultural divergences in subjectivity and experience that are directly relevant for any comparison of therapeutic principles and practices. Fruitful comparison of therapeutic paradigms, however, will first require separate description and elucidation of the respective therapeutic approaches.

Bull Lodge Doctors Yellow Man: Considering Historical Gros Ventre Healing Practice

One of the challenges of explicating Gros Ventre healing tradition for modern professional audiences is the need for supplying the requisite context for facilitating nuanced understanding. As mobile plains horsemen since perhaps 1750, Gros Ventres enjoyed the celebrated life of intertribal raiding and seasonal bison hunting until the extermination of the buffalo circa 1884. Communal circumstances changed dramatically thereafter, inaugurating a century of federal supervision, Christian conversion, cultural devastation, and unrelenting poverty. The Gros Ventre population reached its nadir with just 596 individuals in the mid-1890s. Today, in a tribal community that now includes some 3,500 enrolled members (the majority of whom, for economic and other reasons, do not live within the boundaries of the Fort Belknap reservation), perhaps only three Gros Ventre elders fluently speak our ancestral language. The high ceremonies surrounding our sacred Flat and Feathered Pipe bundles have not been practiced for generations, though sweat lodge and sun dance ceremonies have become commonplace since the Red Pride movement of the 1970s. Still, there are no consensually recognized traditional healers, ritual doctors, or medicine people among the Gros Ventres today (for much more detail concerning Gros Ventre history and culture, see Cooper, 1957; Flannery, 1953; Fowler, 1987).

Describing Historical Gros Ventre Therapeutic Intervention

Four generations ago, Frederick P. Gone labored to record as much of the aboriginal Gros Ventre way of life as he could before its passing with the deaths of his elders. Employed for a time by the Works Progress Administration–funded Montana Writer’s Project, Gone briefly obtained his livelihood by consulting with knowledgeable “old timers” and preserving what he learned in writing for posterity. His magnum opus was a text entitled *Bull Lodge’s Life* that records the auspicious career of Buffalo Bull Lodge (ca. 1802–1886), the most celebrated of Gros Ventre medicine persons (for a published, though redacted, version of this manuscript, see F. P. Gone, 1980). The life and times of Bull Lodge, recounted to Gone by Bull Lodge’s daughter Water Snake in the early 1940s, compose a remarkable life story punctuated by achievements in war, healing, ritual mediation, and political leadership. Bull Lodge’s achievements were only possible owing to sponsorship throughout his life span by powerful other-than-human persons.¹ In the remainder of this section, careful attention to the inaugural occasion of Bull Lodge’s performance as an extraordinary healer will require liberal textual citation (for additional detail, see J. P. Gone, 2006a).

According to Gone’s written account, this *natan-hay-ihih* (“medicine man”) assumed the role of “doctor” at the early age of 40, simultaneously marking his transition to the third stage of life (in keeping with Gros Ventre ethnopsychology, *Bull Lodge’s Life* is structured in four parts). Gone explained,²

So at this age his compassion or pity was aroused very deeply by his uncle’s condition. His uncle, one Yellow Man by name, was a very sick man, and every day his condition became more serious, as he was falling away fast.

Moved by such “pity,” Bull Lodge “couldn’t hold himself any longer, so he declared himself” a doctor. He quickly conveyed to his uncle’s father-in-law how to observe the necessary protocol in formally soliciting Bull Lodge’s therapeutic services. In response to this formal request, Bull Lodge initiated 3 consecutive days of visitation to Yellow Man’s tipi. There he exercised specialized ritual knowledge in pursuit of his uncle’s recovery, routinely praying, “My Father, Above Man, this life you gave me, and the power to heal and cure, I appreciate. Look down on me. I raise a body up again.” These three ceremonial performances were then succeeded by four consecutive

midday consultations with the patient, yielding seven instances of therapeutic ministrations before the patient was pronounced well.

During his second ceremonial performance, Bull Lodge paused to explain his credentials to those gathered in Yellow Man's tipi, saying,

My relatives, this what you [have] witnessed just now of my performance are the results of my fasting, hardships, and sacrifices in the past. There are three places where I have fasted in particular, where I was given the power to heal and cure, namely the Black Butte on the south side of the Big River and east of Big Spring . . . ; and on Grows Tallest Butte in the Many Buttes Mountains . . . ; and the middle butte of the Three Buttes. . . . Whenever I'll have pity on anyone whom I doctor, this day's performance that you witnessed is how I'll bring him back to health. It has been revealed to me that you are all to be my children, and your bodies and health are to be under my care.

Here, Bull Lodge referred to seven fasts on seven buttes in north-central Montana that he completed over a 7-year period beginning at the age of 17. Born into poverty (undoubtedly exacerbated by the fact that his French-Canadian father was unknown to him and therefore uninvolved in providing for him), Bull Lodge adopted a boyhood habit of lingering behind when his band broke camp. He would then search for the recently deserted home site of the Keeper of the sacred Feathered Pipe and kneel to cup his hands over the incense hearth made for the Pipe. Then, he would beseech the Pipe to deliver him from poverty: "I wish there was someone up above who would have pity on me and help me to be a man so that I could live like a man."

At the age of 12, the Feathered Pipe visited young Bull Lodge in the appearance of an "old, old man," who announced,

My child, why do you do these things? . . . This custom that you have adopted for yourself . . . has moved me with compassion. I pity you my child. You will be powerful on this earth, and all you have asked for is granted you.

Subsequently, Bull Lodge experienced a vision in which a specially designed war shield was revealed to him from above. Later, at the age of 17, he was instructed to begin his fasts, the initial one to endure for 7 days and nights with each additional fast requiring one day less respectively until the sequence was completed. During these solitary fasts atop high mountains, Bull Lodge abstained from all food, water, and human company. On the first of these

fasts, Bull Lodge cut off the end joint of his little finger in sacrifice to Those Above. In four other fasts, he sacrificed strips of flesh cut from his chest, arms, and thighs. Each time, Bull Lodge cried and prayed and concentrated on his wish to become "a great man among his people." And, each time, the other-than-human Mountain persons appeared to Bull Lodge, commended him for his tenacity and sincerity, and expressed their pity by sharing with him ritual knowledge for uncommon prowess in war and doctoring. Much of this knowledge pertained in some way to *Bha-ah*, the Thunderbird, who was associated with rainstorms, lightning, and the westerly direction and who originally gifted the Feathered Pipe to the Gros Ventres. The knowledge obtained by Bull Lodge during these sojourns was to be exercised only at subsequent points in his life following designated precipitating events. For example, he did not lead his first war party until instructed to do so at the age of 30, and he did not doctor until, at the age of 40 and in the face of his uncle's suffering, he could "hold himself" no longer.

On the third day in which Bull Lodge ceremonially attended his uncle, he arrived at Yellow Man's tipi before sunrise with his signature ritual objects and continued the therapy in the presence of those assembled:

[Bull Lodge] had his drum, wooden bowl, whistle, and black cloth with him. . . . He then took his drum, and once again holding it up slightly overhead, he prayed, saying, "My Father, Mountain Man, I am about to use these things that were supernaturally attached to the shield that you gave to me [during my youth]. Look down upon me as I perform with them [just] as you showed me how to use them." After saying that, Bull Lodge began to sing. After singing the song once for the singers . . . he turned the drum and singing over to them. And before the singing started, Bull Lodge said, "This time I'll draw with my mouth three times on his chest and three times on his back on the patient." Then the singers started their singing for Bull Lodge. Then he . . . began to draw on the chest of [the] patient. After [this] . . . Bull Lodge drew on the back with his mouth. . . .

Within this excerpt are references to additional facets of Gros Ventre ceremonial practice. For example, Gros Ventre ritual experience generally involved four constituents that facilitate human interaction with powerful other-than-human persons: song, smudge (or "incense" from the burning of sacred plants), pipe, and prayer. Within these ritual interactions, distinctive ceremonial protocols gifted from these beings were strictly adhered to, whether for therapeutic intervention or other purposes. In Bull Lodge's case, his use of

the drum, bowl, whistle and cloth proceeded precisely as he had been instructed. The particular sickness afflicting Yellow Man—never identified in Gone's (or, presumably, Water Snake's) account—was treated in part by sucking an unidentified substance from the patient's body, which Bull Lodge then spat into the wooden bowl.

With the drawing forth of this substance evidently concluded, the ceremony proceeded in a new direction:

Bull Lodge stood up and circled [the] patient completely . . . and then took the black cloth and covered [the] patient with it, after which he took the wooden bowl. And standing up, he began to talk. "My Father, Mountain Man, it was you who appeared to me on the Black Butte, come to me now and be with me as I perform my first experience as a doctor. I need your help." . . . And as he held the wooden bowl in that [upraised] position, Bull Lodge felt as if a slight breath of breeze struck [the] wooden bowl. . . . Then when he felt the breath of breeze, he began to imitate the cry of an eagle. . . . Then he . . . put the bowl down on the ground in front of where he stood, and sat down. The stuff that he had drawn out of [the] patient's chest and back was in the wooden bowl when [he first] stood up . . . but when he put the wooden bowl down, [there] was seen three objects instead. . . . Those three objects . . . were recognizable only to Bull Lodge. One was yellow, one dark blue, and the other was red. . . . These objects were the size of a large marble, and laid in a row at the bottom of the bowl. Bull Lodge passed the wooden bowl to the people [in attendance] so that they can inspect those three things.

In the conclusion of this healing session, those assembled in Yellow Man's tipi witnessed the stunning transformation of the substance drawn from the patient's body into mysterious colored objects passed around for all to inspect. In his remaining therapeutic sessions with Yellow Man, Bull Lodge used these objects to further doctor his uncle.

Following his completion of these 3 days of ceremonial activity, Bull Lodge subsequently met with his uncle for four midday consultations. During these, he stroked Yellow Man with these same objects and prepared medicine for him to drink. At the seventh meeting with his uncle, Bull Lodge finally "pronounced him cured." Yellow Man evidently concurred: "My nephew, you have given life back to me, and I'll live it in appreciation to you." Of course, Bull Lodge's renown as a healer was augmented by his achievements

in other arenas of community life as well, including his war honors and exceptional facility with additional kinds of gifted ritual knowledge:

[His] powers were many and far reaching, he even controlled rain and electrical storms and never was known to loose a case in his doctoring. . . . Therefore he was widely known by the neighboring tribes for his healing and curing powers of even the most hopeless cases of gun wounds and the few sicknesses that the early day Indian[s] were subject to.

Ultimately, his people's respect led to Bull Lodge's selection at the age of 66 to the high office of Keeper of the sacred Feathered Pipe, the very same Pipe to which Bull Lodge had devoted himself as a child more than four decades prior to this crowning achievement.

Explicating Historical Gros Ventre Therapeutic Intervention

The chief purpose of describing in such detail the ritual activities undertaken by this influential 19th-century Gros Ventre medicine man is to facilitate insight into the therapeutic paradigm that structured such activities and rendered them locally intelligible. Obviously, the general characterization of this paradigm depends on much more information than a single therapeutic encounter might provide. Nevertheless, when considered within the sweep of Gone's meticulously detailed account (composing roughly 170 manuscript pages), the central facets of this paradigm begin to take shape. Additional contextualization furnished by Cooper's (1957) ethnological summary of Gros Ventre religious sensibilities—including more than 50 pages devoted specifically to "curing practices"—further attests to the representative nature of Bull Lodge's treatment of Yellow Man. Finally, drawing on contemporary inquiry and experience, the author himself has attempted to cogently systematize and explain some of the less familiar aspects of Gros Ventre ethnopsychology (J. P. Gone, 1999, 2006a; J. P. Gone & Alcántara, in press; J. P. Gone et al., 1999). Such attention has typically been framed in relation to "mental health" approaches and interventions (J. P. Gone, 2004a, 2004b, 2006a, 2006b, 2006c, 2007, 2008e, in press). The brief explication to follow thus owes a great deal to these previous efforts and inquiries.

In terms of a historical Gros Ventre therapeutic paradigm, it would be impossible to overemphasize the centrality of Power to understandings of therapeutic efficacy. Indeed, Bull Lodge's life and career were distinguished principally in Gone's narrative by the many gifts of Power he received from

other-than-human persons. Unfortunately, Power as it functioned in Gros Ventre life is one of most difficult concepts to adequately circumscribe. In brief, Power was understood as the expressive means of persons for achieving their intentions or wishes. In this regard, Power was intimately tied to animus or vitality (i.e., "life," as in "you have given life back to me"), along with certain instrumental properties of thought.³ Human beings possess no vitality of their own (depending instead on the intentionality or "wish" of the One Above, the Prime Thinker, for life itself) and remain very limited in their abilities to exercise Power through their own wish or thought. Thus, one way that humans might obtain greater instrumental potency for realizing their intentions, wishes, or ambitions in the world was to obtain gifts of ritual knowledge from other-than-human persons (or "someone up above"). Such gifts served as the means for amplifying the Power of one's own thoughts even while enlisting the assistance of exceptionally Powerful Others in support of one's intentions. These pursuits harbored the potential for grave danger as well, however, for Power achieves the redistribution of vitality. As a result, the Beings Who exercise Power most potently require strict observation of ritual protocol as an expression of interpersonal deference and respect. Even inadvertent lapses in protocol might result in the diminishment (or even extinguishing) of vitality for ritual practitioners, supplicants, or their families.

Not surprisingly, then, gifts of knowledge were not especially easy to obtain. Insofar as humans ranked near the bottom of the Power hierarchy within the cosmos, access to ritual knowledge from higher-ranking other-than-human persons required a set of prescribed protocols governing moral conduct, interpersonal interaction, and ritual supplication. Most important, lower ranked beings were expected to demonstrate respect toward more Powerful others (through courtesy, deference, supplication, gifts, sacrifice, protocol, ritual obligation, and sometimes even fear and avoidance). In turn, higher ranked Beings might be expected to respond with "pity" (compassion accompanied by the obligation to give) toward less Powerful others (through gifts of various kinds, including instruction in ritual knowledge and subsequent sponsorship of petitioners' pursuit of their ambitions). This is why, following Bull Lodge's boyhood custom of beseeching the Feathered Pipe for help, the "old, old man" appeared to him with welcome news: "I pity you my child. . . . All you have asked for is granted you."

The result of Bull Lodge's entreaties was direction to undertake seven fasts on seven buttes involving almost incomprehensible sacrifice (an offering of respect) and suffering (an evocation of pity). One Mountain person, the wife of the Mountain Man from the middle butte of Three Buttes,

explained just prior to gifting Bull Lodge with a wolverine skin bag full of medicines as follows:

My son, I have pity on you. I am a woman, and usually it's hard for anyone to arouse me to pity. There has been many men who slept on my tipi (meaning the butte), but [I] have never been moved to pity by them. This is one time that I am moved. That's why I tell you that I pity you.

This Being explicitly noted that Her pity was evoked in Bull Lodge's case because he had made a gift (sacrifice) to her son of four strips of flesh from his arms. Thus, it seems clear that Bull Lodge's exceptional achievements in life, including his therapeutic achievements, derived in part from the extent to which he sacrificed various personal resources in pursuit of knowledge from Powerful others.

Clearly, then, Bull Lodge benefited from such pity through his receipt of ritual knowledge, obtained from the Mountain persons as a result of his "fasting, hardships, and sacrifices" in their seven domiciles as well as from the Feathered Pipe. Each of these other-than-human persons appeared to Bull Lodge in dreams or visions and directly instructed him as to the variety of materials he was to obtain, craft, and utilize for success in both war (e.g., his special shield) and doctoring (e.g., his drum, black cloth, wooden bowl, and whistle). It is interesting that Bull Lodge's war shield and healing materials were inherently associated with one another: "I am about to use these things [meaning his healing articles] that were supernaturally attached to the [war] shield that you gave to me." What then was the nature of this attachment? Note that both the war shield and wooden bowl were circular in form, with a depression in the middle lending a "dipped" shape best suited to their distinctive functions (i.e., containing objects vs. repelling objects). The outer edge of both shield and bowl was painted in the likeness of the rainbow, marking their association with *Bha-ah*. Most significantly, both functioned in related roles relative to the protection and enhancement of vitality. In this regard, the "mysterious" metamorphosis wrought by the Powerful Mountain Being of Black Butte was profound, for the life-negating substance drawn from Yellow Man's body was transformed into the life-enhancing objects that appeared in Bull Lodge's bowl, objects that became therapeutically central in the restoration of life to his uncle.

Bull Lodge's use of specialized ritual knowledge likewise maintained his relationships and fulfilled his obligations to the other-than-human persons who originally gifted such knowledge to him. His prayers while doctoring his uncle to "Above Man" as well as to "Mountain Man" included his request

that these persons “look down on me” or “be with me.” It is culturally understood that the “breath of breeze” that transformed the contents of the wooden bowl was the “Mountain Man” from Black Butte Who Bull Lodge had invited to join the proceedings.⁴ Facility with this knowledge, and respectful observation of associated protocol, elevated Bull Lodge in rank among his own people (and other peoples of the northern plains). As one marker of this elevated status, he himself became a human recipient of respect from others and an agent of pity that could effectually redistribute vitality through his own therapeutic ministrations. As Bull Lodge himself explained, “Whenever I’ll have pity on anyone whom I doctor, this day’s performance that you witnessed is how I’ll bring him back to health.” This moral obligation to give out of compassion to those who are pitiful merely replicates the interpersonal principles of the cosmos within human affairs as well.

In any considered discussion of therapeutic practice vis-à-vis professional psychology, attention to the interpersonal principles of the cosmos should not displace attention to the interpersonal principles of the therapeutic relationship between healer and patient. With regard to the celebrated healing encounter between Bull Lodge and Yellow Man, several aspects of their interactions stand out. The therapeutic relationship was a coming together of relatives, for Bull Lodge was Yellow Man’s nephew. The therapeutic relationship was initiated and supported by family members, for Yellow Man’s father-in-law made the formal request to Bull Lodge, and the entire family participated in the ritual activities and assumed the burden of payment for Bull Lodge’s services (including seven horses and other valuable items). The therapeutic relationship was time limited, for Bull Lodge predicted early in his sessions how many times he would need to treat his uncle before restoring him to health. The therapeutic relationship was effective, for Yellow Man did indeed recover from a disabling illness in the predicted timeframe. The therapeutic relationship advanced the social status of the healer, as Bull Lodge not only won honors for curing his uncle but gained additional prestige for generously redistributing several of the items received as payment to nonrelatives as part of the ritual. The therapeutic relationship was socially engaging, for Bull Lodge not only presided over a gathering of family members but also included 13 singers in the ritual, partook of meals with everyone assembled (including the patient), reinforced social ties to other tribal members through associated acts of generosity, and (of course) invited Powerful other-than-humans to join the assembled company.

Perhaps the most important observation concerning the nature of the therapeutic relationship as it was represented in this account is that recognizable *psychological* aspects of the relationship were muted or ignored. Explicit,

complex, or detailed representations of private thoughts, inner feelings, or implicit motivations are almost nowhere to be found in the narrative. For example, only nine brief utterances are attributed to Yellow Man in the 21 pages of text devoted to Yellow Man's healing. Indeed, the most "psychological" portions of the text pertain to the arousal of Bull Lodge's "compassion or pity" for his uncle, to Yellow Man's final expression of gratitude ("I'll live it in appreciation to you"), and to the reaction of Yellow Man's father-in-law on hearing that Bull Lodge agreed to take the case ("He was overjoyed, because he had observed the experiences of fasting and hardships that Bull Lodge went through for seven years"). This muting of psychological phenomena bears noting. In keeping with the interpersonal principles of the Gros Ventre cosmos, the narrative account of traditional healing reviewed here emphasizes rank, status, role, relationship, and protocol much more than personal dispositions, private sentiments, or inner states or processes. In sum, the representation of an important event such as Bull Lodge's inaugural healing encounter is most remarkable for its a-psychological quality. This is not to assume, of course, that no psychology was in force in historical Gros Ventre healing practices, but it does suggest that recovery of that psychology for the purposes of contemporary analysis and explication might be exceedingly difficult in the face of such limited "data."

With this caveat in mind, it seems possible to hazard a few generalizations about the psychological facets of the therapeutic relationship between healer and patient in the historical Gros Ventre context. First, healers were recognized as individuals who had obtained gifts of Power and thus merited expressions of respect from persons of lower status (as in Bull Lodge's pronouncement that "you are all to be my children"). Respect in Gros Ventre life was much more than merely holding someone in high regard but instead included the interpersonal obligation for sober and circumspect behavior while in the respected person's presence. Moreover, such regard frequently entailed respectful avoidance of the individual and might easily shade into fear. Cooper's (1957) elderly Gros Ventre informants, some of whom described personal experiences as patients of ritual healers, sometimes mentioned their fear of healers who doctored them. Second, in addition to this respectful fear, wariness of powerful healers might also arise from misgivings by patients as to whether a particular healer was trustworthy and likely to be effective. Because feeding and gifting such individuals for their efforts was obligatory, the possibility that some self-proclaimed healers would take advantage of their station by duping gullible families, charging excessively for their services, or even requiring sexual favors as part of their payment was anxiety provoking.

Third, then, faith or belief in the healer's intentions and abilities seemed to be a psychological prerequisite for efficacy. In one instance recorded by Cooper (1957), a woman who was married to a healer "bawled out" her sister for requesting the services of her husband: "Why should he doctor you when you have no faith in him?" (p. 334). Healers frequently included in their ritual ministrations a predictive or oracular component, such as Old Spotted Bird's use of the white medicine and black scarf to determine whether he could in fact be helpful. Moreover, most instances of Gros Ventre traditional healing involved the ritual animation of objects (e.g., an animal pelt was witnessed to come to life and assist in the doctoring) or the extraction or transformation of substances that were subsequently passed around to all in attendance for inspection. Such facets harbored the potential to bolster the belief of everyone involved in the efficacy of the healing encounter. Finally, such belief helped to mobilize the most important psychological constituent of the ceremony. In keeping with the purposes of all Gros Ventre ritual (as reviewed above), healing efficacy depended on the effortful concentration of will or wish by all those involved for the patient's recovery. Moreover, the rejuvenating benefits of the ritual were not confined solely to the patient himself. For example, when praying over the food before the first ritual meal of the ceremony, Bull Lodge pleaded, "My Father, Above Man, this food you gave me, I am sharing it with these people who are in this tipi. Put your kind thoughts into this food from above, that they may enjoy it and a long life."

Summarizing Historical Gros Ventre Therapeutic Intervention

By way of brief concluding summary, then, the therapeutic paradigm that structured the 19th-century healing activities of the Gros Ventre medicine man Bull Lodge may be characterized by at least four basic distinguishing features. First, the historical Gros Ventre therapeutic endeavor was a subset of general "religious" expression, the efficacy of which depended on appropriate interpersonal interaction with higher-ranking other-than-human persons. That is, effective therapeutic intervention required suprahuman attention and action. Second, the therapeutic endeavor necessitated instruction by these Powerful Beings in specialized ritual knowledge through dreams and visions experienced by the petitioner. That is, effective therapeutic intervention required the exercise of esoteric ritual protocol. Third, the therapeutic endeavor aimed to achieve a ritual redistribution of vitality or animus toward salutary ends (e.g., longevity and prosperity), but the nature of Power and interpersonal relations with other-than-humans inevitably entailed some risk of danger, harm, or "bad luck" to those involved. That is,

effective therapeutic intervention required the preliminary assumption of risk as well as reward. Finally, the therapeutic endeavor was much more likely to redistribute vitality for the benefit of patients when the ritual practitioner and ceremonial participants fervently wished or intended to see the patient restored to health and competently adhered to every detail of the ritual protocol. That is, effective therapeutic intervention required a scrupulous preclusion of malignant intent and ritual malfeasance.

For most professionally trained psychotherapists in the 21st-century United States, the therapeutic paradigm undergirding Bull Lodge's healing of Yellow Man must seem altogether foreign. If, as Kirmayer (2007) observed, psychotherapy is distinguished from other forms of symbolic healing by its essential "emphasis on explicit talk about the self" (p. 232), then historical Gros Ventre healing practice would seem to be of an entirely different species within the therapeutic genus. Some Gros Ventres today would find Bull Lodge's interventions unfamiliar or even frightening, though as the vignette at the beginning of this article attests, some living Gros Ventres witnessed comparable interventions during their lifetimes. Similar observations regarding traditional healing in American Indian communities more generally have led to a contemporary postcolonial predicament in the provision of "mental health" services for Native clients (Duran & Duran, 1995; Nebelkopf & Phillips, 2004; Witko, 2006; for an early prototype, see Devereux, 1951). To wit, the modern psychotherapies—steeped as they are in Western assumptions regarding self, identity, personhood, social relations, communication, spirituality, and so forth—harbor the implicit potential for effecting ongoing Western cultural proselytization of vulnerable Indian clients (J. P. Gone, 2003, 2004a, 2007, 2008b, 2009; J. P. Gone & Alcántara, 2007). With this predicament in mind, consideration of a second therapeutic encounter that details the salutary ministrations of a contemporary American Indian professional psychologist in his innovative treatment of Native American "patients" follows.

Duran Counsels an Alcoholic Client: Considering Modern Culturally Specific Psychotherapy

Having reviewed in some detail a historical instance of Gros Ventre traditional healing, it is time now to similarly consider a modern instance of culturally specific psychotherapy for American Indian clients. Despite routine overviews of how best to proceed in psychotherapy with American Indians (French, 2002; LaFromboise et al., 1990; Mohatt, 1988; Renfrey, 1992; Trimble, Manson, Dinges, & Medicine, 1984), few elaborated and sustained tutorials have appeared in the literature. As Trimble and Jumper-Thurman

(2002) summarily observed, most of these contributions “focus on bits and pieces of the counseling process” and lack any comprehensive theoretical model that might afford a distinctive form of psychotherapy for Native people (p. 65; but exceptions appear to include Herring, 1999; Reimer, 1999). More recently, however, Eduardo F. Duran (2006) published *Healing the Soul Wound: Counseling With American Indians and Other Native Peoples* as part of the Teachers College series on the multicultural foundations of psychology and counseling. Duran, an award-winning professional psychologist who identifies as Apache and Tewa by ancestry, has offered in this work a notable contribution to the field as evidenced by several distinctive qualities.

First, his book is a culmination of decades of experience by a Native psychotherapist regarding a career’s worth of firsthand clinical interactions with American Indian clients. As a result, the book comprises as grounded and refined a study of the subject as currently appears in the literature. Second, the book is a practical text that contains evocative case material portraying the various therapeutic strategies described and motivated by Duran in his previous theoretical treatises (Duran, 1984, 1990, 2000; Duran & Duran, 1995; Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998). In short, this work illustrates in concrete fashion the significance of these innovations for the therapeutic process. Third, Duran’s book is an unapologetic presentation of an innovative, integrative, culturally specific alternative to more conventional and familiar psychotherapeutic approaches. That is, this effort promotes an unusual adaptation of psychotherapy to American Indian cultural experience to a degree unfamiliar to most multicultural psychotherapists. Finally, this book may well join an earlier publication (Duran & Duran, 1995) in the canon of multicultural therapy literature as evidenced by routine adoption in university counseling courses and widespread familiarity among professionals who work with Native people. In sum, the book promises to influence professional understanding of the distinctive mental health needs of Native American communities and the culturally competent innovations designed to meet them for years to come.

Describing Duran’s Culturally Specific Psychotherapy

A truly adequate description of Duran’s (2006) approach to counseling American Indian people is simply not possible in even an extended article-length contribution. In light of the present purpose, this article endeavors to ground and contextualize certain aspects of Duran’s approach toward the eventual comparison of therapeutic paradigms vis-à-vis questions of cultural commensurability. If the multicultural critique of conventional clinical

activities correctly construes these as potentially alienating, assimilating, or otherwise injurious for American Indians, Duran aspires to remedy the situation through an “alchemical amalgamation of Western theory and Traditional Aboriginal theory and practice” (p. 1). In other words, Duran does not reject the value and utility of Western counseling skills and techniques but instead asserts that their appropriation in Native therapy contexts depends on a fundamental recontextualization of their relevance and use. He explains that “colonization processes affect human beings at a deep soul level,” inflicting a “soul wound” or “spiritual injury” that necessitates a discursive shift “from psychologizing to spiritualizing” in treatment (pp. 14-15). In essence, Duran’s approach deliberately displaces the Western “root metaphor” undergirding the secular and technical assumptions of mainstream psychotherapy with the “organic Native root metaphor” in which the healing endeavor is understood to be a spiritual undertaking. As a result, Duran’s soul wound psychotherapy appears to answer the call for therapeutic integration issued by LaFromboise et al. (1990) almost 20 years ago.

To facilitate the therapeutic transformations required to heal the soul wound, Duran deliberately upsets patient expectations in his first sessions by disrupting scripts “of what therapy should be like” (p. 40). In many instances, the shift from “psychologizing to spiritualizing” orchestrated by Duran in therapy is foreshadowed early on. Such a shift is marked by Duran’s adoption of an unconventional healing discourse rather than conventional therapy discourse, his encouragement of the sharing and interpretation of patients’ dreams, and his typological assessment of patients relative to Jungian personality theory. Owing to the legacy of colonization, however, many of Duran’s Native patients are largely unfamiliar with indigenous spirituality and certainly do not expect to encounter such in psychotherapy (which many have experienced on prior occasions). Drawn from Duran’s (2006) chapter on “The Spirit of Alcohol” (especially pp. 67-73), the session material presented below provides a window on the therapeutic process.⁵ Note that in the published exchange between therapist (T) and patient (P), Duran routinely intersperses the dialogue with commentary—regrettably, there is not space to include this material here.

In this session, Duran is treating a “man in his 40s who has had several attempts at treatment for alcoholism,” accompanied by “underlying problems” including “sadness, anger, unresolved grief, and historical trauma, which continue to fuel the symptoms of alcoholism” (p. 67). In this instance, the exchange of root metaphors commences in a single session, starting with an initial discussion of the presenting problem in which Duran almost immediately begins to disrupt patient expectations about the therapy.

T: What's going on?

P: I'm an alcoholic.

T: How do you know?

P: Well, I'm not in denial. I've been to [Alcoholics Anonymous] and treatment before. I know that this is a disease that is progressive.

T: Sounds like you know more than I do about that.

P: Well, I have been in a few treatment programs and I have studied the AA Big Book.

T: Big Book. That's good. Do they have a little book?

In the commentary that accompanies this exchange, Duran gestures to several simultaneous therapeutic objectives. These include deconstruction of the patient's prior pathologization (referred to as the diagnostic "naming ceremony"), elevation of the patient's status to coequal with the therapist, utilization of humor to defuse any patient "defensiveness" about AA, and intimation to the patient that "not all that is written is necessarily true for him" (p. 68).

Succinct discussion of AA continues:

P: You know, it's all in there. The [12] steps [of AA].

T: How far are you in the steps? That first one is a gnarly one. Man, if I could just understand Step 1, I'd really know something. That Bill W. [the founder of AA] was something else.

P: Yah. Step 1 took me awhile. . . .

In this brief exchange, Duran both reinforces the value of AA (noting that "we don't want to take away any intervention that can help") even as he directs patient attention to Step 1 in the program, which requires an admission of helplessness and the recognition of a Higher Power. This indirect evocation of spirituality paves the way for a significant discursive shift:

T: What do you think that might mean in the Indian way?

P: Well, I know the elders have a lot to say about it. It's a White man's illness. They say that I should get White man's medicine for it.

T: Do you believe that?

P: Well yah, I believe them. But then, there are a lot of elders who drink. It's hard to know what to believe.

Duran observes here that one goal of this query is to assess the acculturation status of the patient even as consideration of the question allows the patient to entertain culturally parallel manners of construing alcohol problems.

Duran furthers the shifting of root metaphors in the subsequent interaction, explicitly reframing the meaning and significance of alcohol in spiritual terms. At this point, Duran acknowledges that in many similar circumstances he would ritually burn sacred sweetgrass or sage (i.e., “smudge”) to establish a “metaphorical spiritual boundary” surrounding the therapeutic encounter, as well as to overtly invoke its ceremonial aspects:

- T: Can I tell you something? The way it was explained to me by a holy man? . . . I was told that alcohol, and all drugs for that matter, are medicine. You know, medicine in the Indian way.
- P: Medicine? Never heard it like that.
- T: You see, when they make alcohol they use all the sacred elements. It’s life that is being transformed from grapes or whatnot. Air, fire, water, and earth are used. That’s what you are made of also, so it knows you. Since it is sacred, it has a dual aspect. Depending on how you use it, the medicine will respond to you.

Here, Duran construes alcohol as originating from a “transformation” of “life” by sacred elements into a “medicine” with intentionality (i.e., “it knows you”). According to Duran, all medicines harbor “dual aspects” for both good and ill depending on their use.

Moreover, only certain kinds of people possess the requisite knowledge to use such medicines appropriately:

- T: Since it’s medicine, it should be used only by those who know medicine, like medicine people. If you’re not a medicine person, you should leave it alone. If you use it anyway, then you are the opposite. Do you know what is the opposite of a medicine person?
- P: A witch or sorcerer.
- T: Yes. When you use the medicine this way, you are doing sorcery on yourself and your loved ones. It’s very scary stuff. . . . Every time you use this medicine, you are taking a big risk. Amazing though. The same medicine can be the “Blood of Christ” or sorcery.

At this point, the root metaphor is well beyond a secular and technical frame of reference. The dual nature of “medicine” as a spiritual entity (evident even in Christian tradition) is further reinforced by consideration of the opposing natures of those who use or misuse it (“medicine men” vs. “sorcerers”).

As Duran explains, such awareness usually “will become very disturbing to patients as they begin to integrate the meaning of this fact” (p. 69):

P: Sounds pretty heavy when you say it like that.

T: It is heavy. You know there is a contract that happens between your spirit and the spirit of alcohol. Spirit knows spirit, and they know the etiquette of spirit even if you don't.

P: What do you mean?

T: When you approach the spirit in the bottle, your spirit recognizes it and the alcohol spirit recognizes your spirit. They enter an agreement. The alcohol spirit lets your spirit know that it will give it something. It can be relief, laughter, sleep, or whatever. Then, your spirit agrees to give something back. What do you think the alcohol spirit wants?

P: I don't know. Hard to tell.

T: Well, because it's spirit it can only want one thing. That is spirit. Your spirit. It could make an exchange, though, and it could want the spirit of someone in your family.

By now, Duran's discursive shift—in which he deliberately displaces the language of *intrapersonal* pathology with the language of *interpersonal* relationship—is all but complete. This then is the signature characteristic of Duran's approach to therapy with American Indian patients, namely, the reformulation of psychological problems as "living entities" in the course of treatment.

This reframing of the therapeutic endeavor is so novel to many of Duran's patients that, at least judging by the case material in his book, resultant expressions of disorientation or astonishment seem normative:

P: Never thought of it like that. How come they didn't tell me this when I was in treatment?

T: They really don't know about this stuff. Actually, if they heard me tell you this stuff they would think I was crazy.

P: Guess they would. You're not like a real psychologist. At least not like any that I've had.

Duran, it seems likely, would accept this latter judgment as a compliment. Besides buttressing the therapeutic alliance between those who share experiences of marginality (as Duran allows in his commentary), he occasionally refers to some mainstream psychotherapists—particularly those who risk harming their Native patients with their colonizing interventions—as "sorcerers."

The resultant relationships between patients and their problems are sometimes cast in ceremonial terms:

T: You know, when you drink or use drugs, it is a ceremony? Let me explain this to you. . . . You step up to the bar, leave your token just like when you go to a medicine person . . . , and request the kind of medicine you want. . . . Then you proceed to drink. . . . You have completed your ceremony. Now, the contract is in place. The medicine will give you what you want. It will keep its part of the bargain. Now it will be up to you to fulfill your part.

Not surprisingly, the gravity of the situation for the patient begins to settle in:

P: It sounds really serious when you talk about it like that. It sounds hopeless. I mean I already did these ceremonies to the spirit of alcohol. I can't undo that. What do I do?

T: There are ways. In the spirit world, it's all about etiquette and manners. So far, you have forgotten these. All traditions have manners when it comes to dealing with these forces.

As an example, Duran colloquially recounts the story of Christ healing the Gerasene demoniac, emphasizing that a "deal" was struck enabling the spirits to enter a nearby herd of swine. Thus, Duran reassures the patient, referencing no less an authority than Christ Himself, that "deals" can be made in the spiritual realm.

Spiritual transactions, of course, require ritual accommodations. It has already been noted that Duran sometimes burns "smudge" during his therapeutic sessions, but beyond this he also readily incorporates prayer, offerings, and "power objects" or "fetishes" in explicit recognition that "therapy is a ceremony" (p. 42):

T: Since you want to let go of the spirit of alcohol, you need to talk to it and ask what it wants in exchange for your spirit. I'm sure you can work out a deal. [Duran reaches for a "fetish" resembling a bottle of cheap "Dark Eyes" vodka.] Here is my friend. We can talk to it now. . . . Dark Eyes is already wondering if you're going to have manners. You know as part of your Step 4 through Step 8 [in AA] that you also need to make amends to the medicine here.

P: How do I do that? What do I say?

T: When you make an offering, you know what to do. You can offer tobacco, cornmeal, food, water, and such. It's the intent that is important, and the spirit of alcohol will recognize the honesty of your spirit as you go into this new way of relating with awareness.

P: I don't have anything on me to give now.

T: Man, what kinda Indian are you? You're out there in the world with no protection.

Thus, Duran facilitates the direct and overt communication between patient and spirit by retrieving the fetish and inviting communication "to get the patient to relate to the energy of alcohol and addiction in a mindful way . . . as part of the ongoing relationship to the spirit of alcohol" (p. 72).

Finally, Duran procures some cornmeal or tobacco from his stash so that the patient can offer this to the fetish "with the intent that the spirit of alcohol will begin to relate to his spirit in a respectful fashion" (p. 73). The patient makes his offering and announces the following:

P: Something happened when I did that. It's as if the spirit recognized me. That is really something. Can't believe that no one has ever talked about this. Except one of my grandmas once said something about this spirit stuff, but at the time I thought she was just talking old crazy stuff.

T: Yes, this knowledge is older than dirt. All of our grandmas knew this. We've just forgotten the way. This brings us back to the "Good Red Road."

Now that the patient has reconceptualized his problem with alcohol by virtue of the "decolonization" process facilitated in the preceding therapeutic interactions, a renewed relationship to himself, his community, and his cultural heritage will together support a renewed relationship to alcohol. In the end, beyond merely recovering from addiction, it is Duran's hope that such patients will experience a "deeper healing of the spirit" (p. 18) involving "an existential reconnection with who they are as a Native person" (p. 66). Perhaps even more significantly, according to Duran, such patients "restore their humanity in a way that is harmonious with natural laws" (p. 14).

Explicating Duran's Culturally Specific Psychotherapy

Once again, the interest in providing so detailed a description of Eduardo Duran's (2006) counseling activities with an American Indian patient is to promote insight into the therapeutic paradigm that structures his culturally specific form of psychotherapy. As with other multicultural counseling approaches, Duran's primary assumption is that conventional, typical, or mainstream therapy is at best irrelevant and at worst iatrogenic for Native

clients. Owing to the historical legacy of the colonial encounter, American Indian people suffer from intergenerational trauma—experienced as soul wound or spiritual injury—that for Duran requires a liberatory, postcolonial form of therapeutic intervention. As a result, Duran seeks to incorporate liberation discourse into his clinical engagement with Native people. He consistently identifies the depredations of Euro-American colonization as the etiological source of rampant distress in American Indian communities and thus believes that diagnosis in conventional mental health practice is itself a “pathologizing and colonizing activity” because it fails to acknowledge the true historical source of dysfunction in Native lives. In response, Duran pursues the therapeutic goal of reframing personal dysfunction as historical in origin and intergenerational in transmission. Such reframing instills a new consciousness in patients that allows them to disidentify with personal problems to discover novel “relationships with the source of their pain so that they can make existential sense of what is happening to them” (p. 15). The result, for Duran, is a form of therapeutic recovery that depends on a liberatory transformation of political consciousness.

Obviously, therapeutic recovery for Duran is about much more than relief from symptoms, management of distress, or restoration of daily functioning. These, of course, are desirable outcomes as well, which may be why Duran celebrates the “postcolonial hybridity” that characterizes his approach. In fact, he reiterates in several places in his book that proficiency in “proven Western methods” and “excellent clinical interventions” is prerequisite to the kind of therapy he promotes. Moreover, he seems to have in mind a good deal of psychodynamic and humanistic technique as inflected by Jungian transpersonal theory—it seems unlikely that Duran would incorporate the latest professionally sanctioned and officially disseminated empirically supported treatments (Chambless & Ollendick, 2001). Nevertheless, his recontextualization of the therapeutic endeavor is striking, for Duran celebrates the original Greek meaning of psyche, construing psychopathology as “soul suffering” and psychotherapy as “soul healing.” Thus, for Duran, personal problems are “not necessarily a sign of pathology” proper in the patient, but instead “the discomfort he feels could simply be his spirit requiring attention from him,” a signal that “perhaps certain aspects of his life need to change” (p. 47). Obviously, this overt emphasis on the centrality and significance of spirit or soul resonates culturally with many American Indian patients, motivating Duran’s signature innovations. Such innovations include adopting the “organic Native root metaphor,” shifting the discursive frame from psychology to spirituality, and invoking ritual interactions with personal problems now construed as living entities. Moreover, although Duran consistently

casts his allusions to spirituality in the language of metaphor, there can be little doubt that “profound spiritual practice” remains at the core of his approach.

In fact, Duran cautions at the outset of his book that practitioners lacking a “fundamental spiritual tradition” are better off referring American Indian patients to other therapists or, alternately, “admitting that they engage in colonizing therapies” (p. 2). For him, the “worst case scenario” is that psychotherapists, “thinking in a linear fashion” rather than in “holistic” terms, will attempt to apply these methods in mechanistic fashion absent the necessary spiritual qualifications. Instead, as soul healers, dedicated psychotherapists must first and foremost attend to their own soul healing:

Your own soul must be healed so that you can attend to the patient who is presenting with a wounded soul. You cannot do for others what you haven't done for yourself. It is imperative that you attend to your dreams and gain a deep understanding of the messages that your soul gives you through dreams, visions, and other synchronistic phenomena. (p. 44)

Clearly, for Duran, dreams and visions are understood to be “vehicles” of spiritual insight and awareness. Beyond this, he recommends a general openness to the variety of “approaches to understanding how people's lives fall out of balance,” especially in light of how individual souls are “influenced by some of the cosmological forces that affect the life-world, in both the personal and collective spheres” (p. 44). Such openness, fluidity, and versatility with regard to spiritual traditions are plainly evident in his therapeutic interactions with patients. In the preceding session, Duran was seen to deftly invoke the religious tenets of AA, certain forms of American Indian ceremonial tradition, and Christian exorcism within a single session.

So what precisely are the requisite tenets of the spirituality that Duran prescribes for this work? To invoke a professional cliché, it would seem that Duran's spirituality might best be characterized as fundamentally, even frustratingly, *eclectic*. Perhaps the most comprehensive overview appears in Duran's (2000) genre-defying *Buddha in Redface*, in which he details his early encounters with his “root Teacher” Tarrence, a “detrribalized” Native (i.e., “an Aboriginal person who does not belong to an official tribe”) living in the mountains of New Mexico. Duran offers a window into Tarrence's wisdom by opening his book with a cryptic quotation from this Teacher (which also appears verbatim in the closing pages of *Healing the Soul Wound*):

There has always been a dream. Everything is still the dream. All that we call creation and Creator is the dream. The dream continues to dream us and to dream itself. Before anyone or anything was, there was a dream, and this dream continues to dream itself until the chaos within the dream became aware of itself. Once the awareness knew that it was, there was a perspective for other aspects of the dream to comprehend itself. . . . It was from the two energies of dream and time that the third was given birth to, and that third one is known as the “dream-time.” Dreamtime is also known as the “mind,” which is by nature luminescent and pure. And the dreamtime mind is reflected by the emptiness of awareness. (Duran, 2000, p. 1; Duran, 2006, p. 136)

Obviously, the significance of dreams and dreaming seems paramount here and presumably for Duran links mind, soul, and the cosmos within a unified whole. Although *Buddha in Redface* perhaps resists “linear” summary and analysis, the thrust of the work seems to be that Duran’s Teacher ultimately embodied a distinctive indigenous American expression of the Buddha, with an accompanying emphasis in his teachings on illusion, impermanence, suffering, awakening, and enlightenment.

It is well beyond the scope of this article to delve further into Duran’s religious sensibilities. A few key implications emerge, however, with relevance for the therapeutic paradigm undergirding his approach to healing the American Indian soul wound. For one, Duran (2006) appears undisturbed by the apparent diversity in indigenous ritual healing traditions. Although he acknowledges “tribal variations in the metaphors of healing,” he counters that colonization has deceived Native people into believing that “we are so different from one another” (p. 7). Moreover, Duran remains unconcerned in the face of seemingly self-evident divergences in religious systems more generally, proclaiming instead that “all of these religions, theories, and ideas are true” (p. 135). Such calming assurances are rendered possible, it would appear, by his belief in the “collective unconscious” in which “human beings are all connected at a collective level of psyche and that this level of psyche is the source of primordial ideas and images of all human beings” (p. 7). In addition, according to Duran, all human beings are indigenous to earth, if only they will trace their ancestry back far enough. He allows that all peoples have been injured by the macro-institutional forces of Western capitalism and colonialism and thus that all might benefit from therapeutic attention to the soul wound (cf. Gustafson, 1997). For Duran, the potency of such attention lies in its ability to reconcile human beings with the earth (through “Earth therapy”) toward ultimate harmony with “natural” laws and processes.

Finally, it may be that any “illusion of difference” between disparate spiritual and healing traditions is simply not worth disquiet or debate. For in keeping with Buddhist principles and the teachings of Tarrence, Duran concludes, “It is the nature of mind to have this empty purity, and no matter what mind-state makes its way across the mind landscape, it is impermanent and empty. Eventually all interventions become useless due to their own inherent emptiness” (p. 136).

Once again, any considered discussion of therapeutic practice vis-à-vis professional psychology requires attention to aspects of the therapeutic relationship between counselor and patient. With regard to the culturally specific “soul wound” psychotherapy promoted by Duran, several aspects of the therapeutic interaction stand out. First, Duran routinely observes that the therapeutic relationship harbors great potential for harm to the Native patient. This seems to be true for several reasons. For one, owing to the legacy of Euro-American colonization, Native patients have suffered a profound wounding of the soul that “Western” therapy actually exacerbates. The result is a shattering of meaningful identity and a host of associated problems. Moreover, many of the patients with whom Duran works have already suffered additional wounding at the hands of mainstream counselors (“sorcerers”) and so commence their relationship with him with misconstrued expectations that require therapeutic reformulation. Furthermore, for Duran, the therapeutic relationship—whether acknowledged as so or not—is a profoundly spiritual interaction in which the psychospiritual status of both therapist and patient might affect either party for good or for ill.

Thus, second, for Duran the therapeutic relationship is characterized by a professionally orchestrated heightening of consciousness for the patient (enlightenment?) that fundamentally reconfigures the patient’s relationship to therapy, pathology, identity, and the self. In other words, far from just imparting adaptive skills or facilitating reflexive insight, Duran’s therapist seems in many respects to occupy the role of “root teacher” for the patient. In this role, the therapist might inspire, model, support, and guide the therapeutic transformation (“soul work”) desired or required by the patient. It is interesting (and ironic) that the liberatory transformation of the patient does not require a “client-centered” approach to treatment but rather a “therapist-centered” approach instead:

In therapist-centered treatment, the therapist understands his spiritual identity and has provided a space in which patients can relate to the entities causing them distress. The therapist also continues to have an ongoing relationship with his soul and the issues that may cause him

difficulties. By doing this, we provide a center from which we can guide the treatment process. (Duran, 2006, p. 45)

In short, it would seem difficult to underestimate the importance of therapist attributes, abilities, and experiences in Duran's culturally specific psychotherapy.

Indeed, in stark contrast to certain empowerment trends within contemporary psychotherapeutic practice, Duran appears to advocate a therapeutic vision in which the therapist functions as much more than a knowledgeable professional. Rather, the therapist functions as a spiritual mentor and guide:

Centering is the process whereby the Healer is in constant awareness of his own soul's healing process. In this teaching, we understand that there is only one center. This center can be attained by anyone who allows for his awareness to become aware of itself in the seventh sacred direction. In this manner, the Healer can assist the patient in finding her own center of the universe. This is the task of the Healer. (p. 46)

For Duran, healing (with a capital *H*) entails the socialization of Native patients—many of whom do not actively practice any religious tradition when they first arrive to see him—into a vibrant personal spiritual practice. Troubled Native patients, it is presumed, are not only in serious want of such experiences but also receptive to and accommodating of these when properly introduced to them by their “centered” therapists.

For express consideration of patient reactions or responses to these kinds of therapeutic activities or of the vagaries and complexities of therapist–patient interaction more generally, Duran is remarkably reticent. While there is much attention to psychology in his work, especially to the theory and practice of professional psychology, his portrait of Native patients (and “other Native peoples”) is strikingly unidimensional. Duran appears to embrace an essentialist notion of Indianness as historically and intergenerationally wounded, spiritually disoriented and displaced, vulnerable to ongoing harm by even well-intended helpers, but otherwise ready to follow natural laws and access the dreamtime. The lived psychology of his patients is largely missing from the account. Insofar as this speaks to the nature of the therapeutic relationship, there is relative inattention to the qualities and attributes that might render individual Native patients more or less suited for soul wound psychotherapy or to the transactional aspects of the therapist–patient interaction that might portend either positive or negative therapeutic outcomes. In sum, Duran considers a great deal of psychological material in his

book, but most of his proposals and claims are nomothetic in nature. That is, he deals in generalized abstractions, so much so that reconstructing any nuanced account of the therapeutic relationship within his distinctive vision is surprisingly difficult in the face of the limited attention he offers.

Summarizing Duran's Culture-Specific Psychotherapy

By way of a brief concluding summary, then, the therapeutic paradigm that structures Duran's (2006) healing of the American Indian soul wound may be characterized by at least four basic distinguishing features. First, Duran's innovative psychotherapeutic endeavor encompasses an "alchemical amalgamation" of spiritual principles, cultural metaphors, psychological theories, counseling techniques, and healing practices of both Western and indigenous origin mustered in support of liberatory transformation for Native patients. That is, effective therapeutic intervention requires a form of postcolonial hybridity explicitly aimed at altering political and spiritual consciousness. Second, Duran's therapeutic approach entails a deliberate shift from Western to Native root metaphors in which indigenous understandings of spirituality and ritual practice figure prominently. That is, effective therapeutic intervention requires the overt recontextualization of clinical activities within the framework of ceremonial healing. Third, Duran's therapeutic approach expands this metaphorical shift toward the explicit identification of patient problems as discrete spiritual entities necessitating ritual expressions of relational obligation and interaction. That is, effective therapeutic intervention requires the personification of pathology to ceremonially mitigate its spiritual potency. Finally, Duran's therapeutic approach espouses a nebulous and eclectic spirituality that appears to perceive harmony between all major religious systems and ideas as expressions of a collective (if ultimately impermanent) human unconscious. That is, effective therapeutic intervention requires transcendent awareness of the unity of humanity in the face of seemingly diverse experiences and the possibility of transformation in our collective relationships to all forms of life on earth.

Comparative Assessment of Traditional Healing and Integrative Psychotherapy

The purpose of such detailed attention to the preceding encounters was to formulate nuanced characterizations of the distinctive therapeutic paradigms undergirding the activities portrayed and to render them legible for comparative purposes. Of course, the great diversity of perspectives and purposes that

might be brought to bear in such comparative efforts renders the circumscribed exercise to follow a rather meager beginning. In presenting and explicating these therapeutic interactions, it is hoped that adequate detail has been provided for readers to undertake informal comparative analyses of their own. Moreover, the acuity of such analyses assumes that the written accounts of these interventions correspond, at least in approximate fashion, to the actual activities of these practitioners when engaged in their healing activities (and there is no evidence that they do not). Finally, for the comparison to be useful, each account must presumably “stand in” for (or represent) some broader collection of practices. More specifically, Bull Lodge’s treatment of Yellow Man should generalize not only to his treatment of other patients but also to the treatment of other patients by other Gros Ventre healers. Likewise, Duran’s treatment of his alcoholic patient should generalize to his treatment of other Native patients and their presenting problems. With regard to the former, detailed ethnographic data collected by Cooper (1957)—not to mention unpublished vignettes such as the one opening this article—attest to the generality of many of Bull Lodge’s therapeutic activities. With regard to the latter, additional case material published and explicated by Duran (2006) attests to the generality of this approach within his innovative work.

Perhaps the most obvious point of demarcation between these approaches pertains to the specific contexts in which Bull Lodge and Duran ministered to the health needs of their respective patients. Bull Lodge attended to Yellow Man in a tipi located within a Gros Ventre camp somewhere on the northern plains during the mid-19th century. By contrast, Duran typically attends to his patients in an office located within reservation-based, Indian Health Service-funded medical clinics in the early 21st century. The century and a half that distances these approaches reveals strikingly different historical and cultural contexts—nomadic plains Indian camp life on one hand and the modern medical clinic on the other—that have given rise to and sustained therapeutic intervention with American Indians. As a relevant aside, it should be remembered that modern health care services remain the primary venue through which psychotherapy is made available to ethnoracial minority constituencies, including American Indians (J. P. Gone, 2003, 2004b, 2008a, 2008c, 2008d). Brief consideration of the ways in which these distinctive contexts differ in terms of relevant assumptions and orientations will set forth the principal domains of divergence that any integrative effort—including Duran’s (2006)—must traverse if it is to achieve its purpose. In short, attention to the following conceptual domains will set the stage for ultimate assessment of the prospects for integration or inclusion of American Indian

traditional healing within mainstream health care programs and practices more generally.

Traditional Healing vis-à-vis Modern Health Care

The overarching challenges confronting the integration of traditional healing and modern psychotherapy for American Indian people are the formidable differences in ontology and epistemology that structure indigenous healing traditions and modern health care, respectively. It is by now a cliché in the literature to enumerate a laundry list of dichotomous cultural contrasts between Native and Western therapeutic traditions to illustrate such differences (Arnold & Bruce, 2005; Camazine, 1980; Deuschle, 1986; Locust, 1995; Morse, Young, & Swartz, 1991; also, for a critical review, see chapter 10 of Waldram, 2004). The most important of these remain worthy of careful attention, however, as conscientious consideration will make evident the potentially profound obstacles to achieving therapeutic integration between paradigms such as those exemplified by Bull Lodge and Duran. These potentially profound obstacles originate in the philosophical legacy of the Enlightenment and the subsequent advent of modernity, in which hope for humanity was rekindled by secular humanism and the instrumental sciences in the face of a progressive disintegration of age-old structures of authority and tradition (Gellner, 1988).

Cultural divergences between traditional healing and modern health care can be located across this philosophical divide with evident implications for present-day efforts toward integration (for greater consideration of what is at stake in the human sciences over this philosophical rift, see Shweder, 1984). In light of this sweeping historical transformation, it is suggested here that the three most important cultural contrasts to keep in mind regarding these distinctive modalities of therapeutic intervention are an interrelated set of differentiations, namely *secular–sacred*, *rational–mystical*, and *technical–relational* divergences, respectively. For much of what follows, general indebtedness is incurred to Anderson (2001), Bird-David (1999), Darnell (1981), Hallowell (1955, 1976), and Morrison (2000). The reader should keep in mind, however, that the great diversity in practices of traditional healing—even within American Indian healing traditions—requires advance caveat and qualification of the potential for these contrasts to apply in every potential instance of comparison. Nevertheless, the following will certainly be seen to illuminate the comparison of historical Gros Ventre healing tradition and Duran's soul wound psychotherapy (and many related comparisons as well).

Secular–sacred divergences. The most obvious cultural contrast between modern professional and indigenous therapeutic modalities is that contemporary health care typically embraces a *secular* epistemology whereas most traditional healing requires a *sacred* cosmology. That is, inquiry in modern health care assumes that therapeutic knowledge and practice are essentially dependent on naturalistic understandings and materialist explanations of human experience. Thorough knowledge of this kind of inquiry (e.g., the questions, conclusions, and methodologies of the social and health sciences) is thus prerequisite to becoming a psychologist, and scientific proficiency in the investigation of these domains is required for the generation of innovative professional knowledge. Such innovative knowledge thus emerges from publicly vetted and skeptically scrutinized advances in naturalistic understanding and materialist explanation regarding how both normal and pathological experience unfolds in predictable, deterministic, and (all-too-often presumed) universal terms. In this view of the therapeutic endeavor, secular, public, vetted knowledge fuels endless optimism for the possibility of professional progress.

By contrast, many forms of traditional healing assume that therapeutic knowledge and practice are essentially dependent on revealed understandings and religious explanations of the human condition. Thorough knowledge of ritual mediation and ceremonial supplication (in the context of potentially dangerous interactions with Powerful other-than-human persons) is thus prerequisite to becoming a healer, and apprenticed instruction in the nuances of religious practice as it illuminates diagnosis and treatment of individual dysfunction leads to the historical reproduction of these traditions. Relatively personalized configurations of ritual knowledge, however, are gifted to individual healers from specific other-than-human persons, so that epistemological progress over time is neither of interest nor concern. In this view of the therapeutic project, religious, clandestine, and potentially dangerous knowledge requires prudent containment within an exclusive set of circumspect contexts affording appropriate and effective ritual exercise.

Rational–mystical divergences. One extension of this secular–sacred divergence is a second cultural contrast between modern professional and indigenous therapeutic modalities, namely, that contemporary psychology participates in a *rational* approach to knowledge whereas traditional healing frequently invokes a *mystical* approach to understanding. That is, modern psychology assumes that therapeutic knowledge and practice are essentially dependent on the powers of creative and clever human reasoning to define fields of inquiry, identify methods, classify phenomena, deduce principles, infer relationships, and solve a host of related problems that are fundamentally

amenable to rational inquiry. Few psychologists would claim, of course, that the *unaided* powers of human reason are independently sufficient for these important tasks, however, as the limits of human rationality have themselves been rationally demonstrated by psychologists, philosophers, and others. As a result, these limited powers of human reason have been augmented by the development of research designs and statistical procedures that control for the fallibilities of human cognition even as they extend the realm of rational human knowing. From the perspective of modern professional psychology, then, authoritative answers to pressing therapeutic questions will depend less on compelling anecdote or illuminating illustration and more on empirical results from systematic, progressive, and rigorous research designs.

By contrast, many forms of traditional healing assume that therapeutic knowledge and practice are essentially dependent on the Powerful activities of other-than-human persons whose motivations and actions remain largely inscrutable to human beings. Knowledge in this context is thus mystical rather than rational in at least two senses. First, the intrinsic or essential nature of other beings—including other humans—is understood to determine their motivations and actions, but this essence cannot easily be known by others owing to the perennial prospects for *metamorphosis* (whether literal or figurative). In other words, outward appearances can be deceptive (as revealed by innumerable myths in which other-than-human persons assume a variety of forms to trick others; for examples among the Gros Ventre, see Kroeber, 1907). Thus, tremendous caution in arriving at conclusions about the essential but mysterious natures of others is warranted. This is routinely evident in the use of considerable indirection in speech and noninterference in interaction in Native communities (Darnell, 1981). Second, the means by which other-than-human persons exercise Power almost always remain mysterious. That is, the essential nature of Powerful others happens to include the ability to exercise such Powers through the expression of desire or intent by means which can never be rationally understood or mechanistically described by humans. In other words, the workings of Power—even when harnessed by knowledgeable humans entrusted with healing gifts from these Beings—retain ineffable and mysterious qualities. From the perspective of traditional healing, then, authoritative answers to pressing therapeutic questions will depend less on searching intellectual efforts to systematically characterize associated phenomena in rational terms. Instead, such answers will be derived from revelatory gifts and partially disclosed understandings that retain an inherent mysteriousness in which as many questions remain unaddressed as are answered (for a relevant case study among the Gros Ventre, see J. P. Gone, 1999).

Technical-relational divergences. An extension of this rational-mystical divergence yields a final cultural contrast between modern professional and indigenous therapeutic modalities, namely, that contemporary psychology increasingly construes its salutary efforts in *technical* terms whereas traditional healing often construes its salutary efforts in *relational* terms. That is, given a prerequisite therapeutic alliance between counselor and client, modern professional psychology assumes that efficacious knowledge and practice are essentially dependent on transportable skills, procedures, remedies, and techniques for the assessment and treatment of patients that any competent expert should be able to utilize. Otherwise, what do years of formal doctoral training and supervision impart? Therapeutic efficacy is thus typically grounded in mechanistic accounts of intervention to outcome, whereby presumed causal pathways and etiological processes are circumvented, interrupted, or rehabilitated through expert application of authorized procedure or technique. The entire endeavor depends, of course, on patient presentation for assessment and compliance with treatment, but the efficacy of technical intervention is primarily a function of materialist knowledge of therapeutic process and outcome rather than the innate interpersonal qualities of either counselor or client within the usual dyadic interaction.

By contrast, most forms of traditional healing assume that therapeutic knowledge and practice are essentially dependent on *relationships* with more Powerful others who compassionately share gifts of healing in exchange for respectful offerings and ritual observance. Traditional healing is thus fundamentally concerned with interpersonal interaction extending well beyond the dyadic patient-healer relationship to the necessary inclusion of particular other-than-human persons, ritual helpers (e.g., drummers and singers), family members, and so forth. Its chief characterization would be *mediation* between vulnerable individuals who suffer and Powerful Beings who can restore humans to wellness. Therapeutic efficacy becomes a function of interpersonal relations in which strict adherence to ritual protocol by the mediating healer helps to assure a favorable hearing by those who are petitioned even as it prevents harm that might result from inadvertent disrespect or interpersonal offense. Ritual healing protocols are gifts of knowledge from other-than-human persons to human mediators for the purposes of accessing Power, but these protocols are neither instrumentally efficacious in and of themselves nor mechanistically transportable to others. In sum, the efficacy of traditional healing depends wholly on the interpersonal rather than on the mechanistic, on the relational rather than the technical. Indeed, such qualities typically express and reinforce cosmologies in which the instrumental manipulation of naturalistic mechanisms (as opposed to social engagement in

interpersonal interactions with all “things” animate) is either heavily deemphasized or largely unknown (Morrison, 2000).

Even brief consideration of these context-sensitive contrasts between therapeutic modalities—insofar as they differentiate traditional healing and health services-based psychotherapy respectively—would suggest that systematic rapprochement between these therapeutic paradigms is likely beset by serious complications before it even gets off the ground. Nevertheless, calls by multicultural professional psychologists for therapeutic integration presume that complications such as these might be met and addressed in creative fashion. In attempting to develop an integrative psychotherapy of his own, Duran (2006) provided the opportunity to critically assess the prospects for this overarching endeavor. And so, with respect to these conceptual abstractions, what does concrete comparison between Bull Lodge’s and Duran’s respective therapeutic approaches actually reveal about the prospects for the therapeutic integration of traditional healing and modern psychotherapy for American Indians?

Ritual Healing vis-à-vis Integrative Psychotherapy

In light of these anticipated domains of cultural divergence, several significant contrasts between historical Gros Ventre healing tradition and Duran’s culture specific psychotherapy are readily apparent. For Bull Lodge, the pursuit of a celebrated career was an expression of individual agency, tenacity, and ambitious achievement, whereas for Duran the pursuit of the healing endeavor is most appropriately ego effacing lest therapists become potentially dangerous to their patients. Bull Lodge’s qualifications as a healer included solitary vision quests and sacrifice to other-than-human persons in pursuit of ritual knowledge for therapeutic purposes, whereas Duran’s qualifications as a psychotherapist include doctoral training in psychology as well as state licensure to practice professionally. For Bull Lodge, the therapeutic encounter required a cadre of ritual helpers as well as the participation of relatives of the patient, whereas for Duran the therapeutic encounter is primarily dyadic within the “confidential” spaces of health service systems. Bull Lodge’s healing ministrations principally involved the exacting exercise of ritual protocol in deference and supplication to the Beings who gifted such knowledge, whereas Duran’s healing ministrations principally involve verbal communication regarding the self-referential experience and holistic significance of patient problems. For Bull Lodge, esoteric knowledge for healing and other purposes was gifted by other-than-human persons through dreams and visions for specific pragmatic purposes such as prowess in war or

doctoring. By contrast, for Duran, esoteric knowledge was apparently gifted by teachers and the “dreamtime” for more existential purposes such as personal enlightenment and the casting off of illusions that can only yield suffering.

Moreover, for Bull Lodge, efficacious therapeutic activity was dependent on ritual protocol that had been gifted to him for his own personal use without succession, whereas for Duran therapeutic activity was dependent on reframed and redeployed counseling techniques that he teaches to professional interns and promotes in his book. Human suffering was deemed undesirable by Bull Lodge with the exception of deliberate sacrificial actions performed to attract notice and compassion from higher ranking Others, whereas for Duran it apparently remains the essence of human existence and drives the pursuit of enlightenment. For Bull Lodge, considerations of cultural discontinuity and Western colonization did not figure prominently in his ritual activities (at least until the disturbing visions of his final years), whereas for Duran such considerations are essential and require fluid postcolonial hybridity and heightened political consciousness in response. Bull Lodge’s healing activities were culturally tailored to the indigenous communities of the northern plains, whereas Duran’s healing activities are promoted as culturally relevant for all American Indians and “other Native peoples.” Most important for Bull Lodge, therapeutic intervention was principally the ceremonial invocation of specific other-than-human persons with the suprahuman Power to restore humans to wellness. By contrast, for Duran, whose “nonlinear” religious sensibilities seem to defy cogent explication, therapeutic intervention is principally the existential transformation in cultural frames of reference by which the activities of Bull Lodge and other indigenous healers are metaphorically harnessed for their inspirational (i.e., enlivening or revitalizing) power in patient lives.

And yet despite these (and numerous other nontrivial) divergences, Bull Lodge and Duran evidenced a surprising degree of convergence in their approaches to therapeutic intervention as reflected in their respective encounters. Both Bull Lodge and Duran were seen to pursue lifelong engagements with the numinous that involved personal encounters through dreams and visions with other-than-human persons. The knowledge obtained in these personal encounters provided the foundation on which their therapeutic activities depended. Both Bull Lodge and Duran were seen to engage in healing activities with acute awareness that salutary outcomes depended on both competent execution of “protocol,” sincerity of compassionate intent, and prayer to Powerful Others. Both were seen to recognize that in principle their respective therapeutic approaches harbored the significant potential for harm

to patients stemming from either inadvertent or deliberate lapses in interpersonal obligation and responsibility. Both Bull Lodge and Duran were seen to overtly activate a ceremonial context for their therapeutic interventions through elaborate ritual activities marked as such in terms of indigenous cultural praxis. And both were seen to acknowledge and regard the animus or vitality of much of the world as an essential component of their therapeutic interventions.

Moreover, at higher orders of abstraction, there is still more in common between the therapeutic approaches of Bull Lodge and Duran, respectively. Many counseling psychologists maintain interest in the so-called “common factors” that are seen to characterize psychotherapy in general, regardless of theoretical commitment or recommended technique (Lambert & Ogles, 2004; Wampold, 2001). Perhaps the most celebrated treatment of this proposal was published by Jerome Frank in his influential book, *Persuasion and Healing* (now in its third edition, as coauthored with his daughter). To briefly summarize, Frank and Frank (1993) identified four “effective features” that characterize all psychotherapies: (a) a confiding and emotionally charged relationship with a healing person, (b) a healing setting, (c) a conceptual scheme or rationale (myth) that furnishes an explanation for patient symptoms and provides a procedure (ritual) for treating them, and (d) a procedure (ritual) that requires active participation by both therapist and patient, which both recognize as a means for restoring patient health.

The “myths” and “rituals” observed in healing encounters might vary quite dramatically, of course, but according to Frank and Frank (1993), these serve a common function:

Despite differences in specific content, all therapeutic myths and rituals have functions in common. They combat demoralization by strengthening the therapeutic relationship, inspiring expectations of help, providing new learning experiences, arousing the patient emotionally, enhancing a sense of mastery or self-efficacy, and affording opportunities for rehearsal and practice. (p. 44)

Of particular interest in this conceptual framework is the centrality of the “therapeutic relationship”: the active and interactive roles of both healer and patient. The importance of these interactions would be difficult to dispute, and it is regrettable that the Bull Lodge and Duran accounts afford such little insight into the interactive nuances of their respective therapeutic relationships. Future psychological explorations of traditional healing would benefit from careful analysis of additional data in this regard. In the present instance,

what seems most clear is that, despite rather dramatic divergences “in specific content” between their respective approaches, the healing activities of both Bull Lodge and Duran might together be subsumed under the rubric of Frank and Frank’s deliberately broad construal of psychotherapy.

Appraising Duran’s Therapeutic Integration

Formal comparison of historical Gros Ventre traditional healing and integrative soul wound psychotherapy has yielded a medley of convergences and divergences that warrant collective appraisal. At the outset of this comparative exercise, it was observed that a truly successful integrative psychotherapy must traverse three major domains of divergence relative to American Indian traditional healing to have responsibly bridged the disparate historical and cultural contexts in which these distinctive forms of intervention have arisen. With regard to secular-sacred divergences, even though Duran works with his American Indian clients in clinical settings, it seems clear that “profound spiritual practice” is central to soul wound psychotherapy, so much so that practitioners lacking a well-developed spiritual life were strongly cautioned against adopting this approach. With regard to rational–mystical divergences, it seems clear that Duran’s unconventional numinous experiences and “non-linear” eclectic religious sensibilities are the theoretical wellsprings of his soul wound psychotherapy, so much so that his “therapist-centered” work appears to routinely establish him as a spiritual guide or mentor for his clients as they learn to explore the “dreamtime.” With regard to technical–relational divergences, it seems clear that Duran’s signature achievement in his soul wound psychotherapy is the reframing of personal problems as spiritual entities that require ceremonial interaction and reconstituted relationship. In these domains, Duran appears to have sided with Bull Lodge on the sacred, mystical, and relational poles of these context-driven oppositions. In sum, given the widely divergent cultural formations that gave rise to historical Gros Ventre healing tradition on one hand and modern psychotherapy on the other, the degree to which Duran has bridged this divide in his culture specific psychotherapy is rather remarkable.

It is finally time to return to the key question that originally motivated this comparative exercise: How much “culture” is required for the culturally competent practice of psychotherapy with the culturally different? On one hand, it is unreasonable to imagine that professional psychologists might themselves become traditional healers. Indeed, among the relatively intimate circle of a few hundred Native American psychologists in the United States, the author is aware of just one professional who sought to apprentice himself

to ceremonial leaders among his own people. On the other hand, it is difficult to see how merely cosmetic adaptations of conventional psychotherapy for American Indians—dressing mainstream approaches in paint, beads, and feathers—will avoid the potential for assimilation, alienation, and injury against which so many multicultural psychologists have warned for a broad swath of the Native population. Because distinctive forms of traditional healing remain the exemplars for culturally competent therapeutic intervention within diverse communities, substantive integration of at least some culture-specific facets and components of traditional healing with the conventional approaches and techniques of psychotherapy is key to the development of culturally tailored counseling interventions. If the endpoints of the integrative continuum thus include conventional psychotherapy at one extreme and traditional healing at the other, how are professional psychologists to judge the merits of integrative efforts that fall somewhere in between? In response to this question, it is proposed here that such evaluations will depend on both *pragmatic* and *aesthetic* considerations. Appraisal of Duran's integrative soul wound psychotherapy in these terms will afford insight into how such considerations might be brought to bear.

With regard to pragmatics, proponents of multicultural psychotherapy (and their employers and sponsors) will want to know whether Duran's healing of the soul wound actually *works* (questions of efficacy) and whether it can be implemented for more widespread use with American Indians and other Native peoples (questions of portability). In terms of therapeutic efficacy, Duran (2006) has written that chart reviews of American Indian patients spanning 9 years of practice attest to the efficacy of his approach, but, of course, such casual assurances will not be persuasive in the age of empirically supported treatments and evidence based practice. Not surprising, in celebration of the mystical over the rational, Duran himself expresses deep skepticism toward the scientific evaluation of therapeutic interventions, and it is easy to imagine that random assignment to "soul wound" psychotherapy might quickly break down, rendering experimental evaluations of its efficacy probably impossible. Nevertheless, systematic evaluation of this approach beyond impressionistic chart reviews conducted by the principal therapist would seem plausible if its practitioners are open to the utility (if not the validity) of robust outcome assessment. In terms of therapeutic portability, there is no evidence that *anyone* has been trained to proficiency in the practice of this therapeutic approach. Indeed, Duran's unconventional religious perspectives and his intermittent warnings that most therapists are not spiritually anchored enough to effect positive outcomes with Native patients represent intimidating obstacles to more widespread implementation of this

American Indian culture specific psychotherapy. In sum, many professional psychologists might object that Duran's integrative soul wound psychotherapy appears to have incorporated so much "culture" that it can be neither rigorously assessed nor readily disseminated.

With regard to aesthetics, proponents of multicultural psychotherapy (and their colleagues and critics) will want to know whether Duran's healing of the soul wound is in fact *culturally specific enough* to warrant celebration and adoption by mental health providers working in Indian country. There are currently more than 560 tribal entities recognized by the federal government in the United States, representing scores of distinctive linguistic and religious traditions and a variety of historical strategies for engaging Euro-American actions and ideals. Thus, there is no "Generokee" cultural essence that might guide the development of a singular culturally adapted psychotherapy targeting "Native peoples" as such. As a result, Duran's soul wound psychotherapy is an imaginative project that actively *creates culture* on behalf of his clientele even as it deliberately *invokes culture* for its authority and legitimacy. Such culture making is especially evident once the therapeutic metaphors are peeled away and the spiritual *bricolage* behind them is made apparent: Duran's "culture specific" psychotherapy appears to owe more to Buddhism, Carl Jung, liberation politics, and the New Age movement than anything indigenous to the Western hemisphere. In sum, many professional psychologists might object that Duran's integrative soul wound psychotherapy appears to have *invented tradition* in the name of *preserving tradition*, harboring the potential to further dilute and distort historically endangered indigenous therapeutic approaches.

And yet Native peoples have for far too long been imprisoned by the imperialist nostalgia of others—all too frequently made our own—for the unspoiled splendor of the pristine, primal past. In a powerful philosophical treatise, Lear (2006) considered the ethics of existence in the face of devastating cultural collapse among the Crow Indians of Montana. In speculating on the constituents of a revitalizing "radical hope" for a new and sustainable future, Lear wrote,

What would be required . . . would be a new [tribal] poet: one who could take up the [tribal] past and—rather than use it for nostalgia or ersatz mimesis— project it into vibrant new ways for the [people] to live and be. Here by "poet" I mean the broadest sense of a creative maker of meaningful space. The possibility for such a poet is precisely the possibility for the creation of a new field of possibilities. No one is in the position to rule out that possibility. (p. 51)

In the end, it may well be that Eduardo Duran—a self-identified postcolonial hybrid—remains such a poet. Certainly, the reviewers of his book who have published their own assessments of his approach in the psychological literature seem to think so (Clearing-Sky, 2007; Reynaga-Abiko, 2006). As is the case for aesthetics more generally, however, such judgments often lie in the eye of the beholder: The prospects for designating evaluative criteria that might ultimately transcend nonrational (as opposed to irrational) regimes of taste and preference in these matters would seem elusive indeed.

Implications for Integrating Traditional Healing and Modern Psychotherapy

Duran's (2006) culturally specific psychotherapy, while effectively bridging American Indian traditional healing and modern Western psychotherapy in many important respects, remains largely unavailable to Native clients owing to severe constraints with regard to its practice, training, and dissemination. To reach a broader swath of American Indian clients, alternative integrative projects will need to be undertaken. Recall that *substantive integration* of approaches or techniques of both traditional healing and psychotherapy was deemed necessary to ensure that culturally diverse clients receiving modern therapeutic services are not merely duped into participating in culturally disguised but otherwise conventionally intact counseling interventions. The underlying assumption, according to the multicultural critique within professional psychology, is that such conventional interventions are potentially alienating, assimilating, or otherwise injurious for the "culturally different." Such concern is certainly not unfounded, as alternative explanations for why a disproportionately high percentage (55%) of American Indian clients failed to return for their second session of psychotherapy across some 17 community mental health clinics in the Seattle area are difficult to fathom (Sue, Allen, & Conaway, 1978).

Nevertheless, for several decades now, psychotherapy has been proven scientifically to genuinely assist persons in distress (M. L. Smith, Glass, & Miller, 1980). Thus, the central issue is not whether psychotherapy should be alternately celebrated or disavowed (and thus recommended or prescribed) in some abstract and objective sense but rather *for which kinds of persons* should psychotherapy be alternately celebrated or disavowed (and thus recommended or prescribed). In the present context, Duran may have put it best: "Man, what kinda Indian are you?" Specifically, the key question relative to therapeutic practice with American Indians pertains to the nature of Native personhood across the acculturative spectrum (e.g., sociocentric or

ecocentric versus egocentric configurations of the self; Kirmayer, 2007). Certainly, some Native individuals can and indeed have benefited from conventional psychotherapy. Some have benefited from culturally modified psychotherapy. Still others have not benefited from the available offerings at all. The resultant professional dilemma is simply (or, perhaps, “complexly”) how to design and provide a greater diversity of therapeutic services that might benefit Native individuals across a wider spectrum of cultural affiliation and practice. This would seem especially necessary for those Native people who occupy culturally distinctive—and therefore professionally unfamiliar—forms of subjectivity and who, if they even enter and return for psychotherapy at all, are not typically signing on for programs of tacit Western cultural assimilation. This is why it stands to reason that substantive integration of traditional healing and modern psychotherapy might bridge the gap for many of these kinds of Native clients.

The foregoing comparative assessment of American Indian traditional healing and modern integrative psychotherapy has illuminated specific convergences and divergences between the documented therapeutic activities of Bull Lodge and Eduardo Duran. It should now be clear that the bottom-up strategy for exegesis adopted in this article tends to accentuate the *differences* between traditional healing and modern psychotherapy rather than the *similarities* between these practices. This is so primarily because the resemblances across such divergent domains of activity tend to be most visible at higher-order levels of abstraction rather than in concrete instances of therapeutic ministrations (à la Frank & Frank, 1993). This final substantive section of the article finally turns to an examination of the implications of the preceding convergences and divergences for future efforts to integrate American Indian traditional healing with conventional psychotherapy for those contemporary Native people most likely to benefit from such a synthesis. First, some relevant considerations stemming from the *contemporary* contexts that will influence future therapeutic integration efforts are described. Second, a review of four practical challenges that confront on-the-ground therapeutic integration efforts is offered. Finally, an innovative approach for advancing the integration of American Indian traditional healing and modern psychotherapy is presented.

Contemporary Contextual Considerations

Throughout this article, Bull Lodge’s therapeutic approach has been consistently qualified as a *historical* instance of Gros Ventre healing tradition as it functioned prior to the depredations of Euro-American colonization in this

hemisphere. Obviously, a great deal has changed—and dramatically so—for American Indian peoples and their cultural practices during these past centuries, including resultant shifts in “traditional” healing practices. The ideological dilemma here is to support the many (though by no means all) Native people who are choosing to engage in community-based projects of cultural reclamation and revitalization without succumbing to a postmodern nostalgia for some pristine and untainted “authentic” premodern indigenous tradition by which all subsequent modifications and adaptations are found wanting in comparison. Processes of cultural change are endemic to the human condition, and despite much Native grief in the face of sudden and pervasive colonial disruptions, exiling indigenous peoples to the conceptual state of eternal premodernity will not serve Native interests in an increasingly globalized world.

To complicate matters further, American Indian people have adopted a variety of opinions concerning whether and how to pursue cultural reclamation, particularly with regard to indigenous ritual practices. It is crucial to recognize that many Native communities evidence vigorous cultural contestation regarding these practices, whether between evangelical Christians and Native “traditionalists,” or among traditionalists. Thus, depending on a given Native individual’s religious persuasion, *active belief* in traditional healing practices might be articulated as either evidence of ongoing authoritative ritual tradition, or alternately as evidence of diabolical and deceptive Satanic influence in the world. Similarly, *active skepticism* toward traditional healing practices might be articulated as either a rejection of a given healer’s authority and credentials (by contrast to genuinely effective healers known within the community), or alternately as a rejection of the claim that *any* forms of traditional healing (and the rather esoteric knowledge that accompanies them) have managed to survive the colonial encounter.

Beyond these alternatives, most Native communities also acknowledge particular instances of exploitation in which an occasional tribal member pretends to engage in traditional healing for flagrantly manipulative and self-serving purposes. As was described for Bull Lodge’s therapeutic approach, ritual access to Power for the purposes of healing is also commonly seen to entail some risk to those involved. Moreover, it was usually recognized that Power might also be accessed for a variety of intentionally malevolent purposes. In sum, given these nuances, the politics of traditional healing in contemporary Native communities can seem bewildering (but see the special issue of *Medical Anthropology Quarterly* for a sophisticated and illuminating treatment of these politics among the Navajo; Csordas, 2000). Suffice it to say, that some—perhaps many—American Indian people are not

as eclectic, inclusive, or accepting as Duran when it comes to their assessment of contemporary articulations of traditional healing. Multicultural professional psychologists with aspirations for facilitating novel integrations, however, will need to chart a clear path through these prickly thickets.

Finally, with regard to health care services contexts more generally, it is important to note that any effort toward the integration of traditional healing remains almost always a unidirectional affair. That is, some combination of political advocacy by tribal leaders and progressive encouragement by the health care establishment has on occasion resulted in a set of circumscribed prospects for integrating American Indian traditional healing *into* established health care services (though less so for integrations with psychotherapy proper). In short, this movement does not seem to be other than incidentally concerned with integrating established counseling or other health care procedures and practices into traditional healing. A host of dilemmas thus arise from the fact that traditional healing—a set of cultural practices that American society explicitly sought to eradicate from Native communities for more than two centuries—might be endlessly construed as pursuing acknowledgement, acceptance, and legitimacy within the mainstream institutions of modern health care. Obviously, such institutions represent a radically divergent discursive domain that nevertheless continues to wield extremely asymmetrical power vis-à-vis indigenous therapeutic traditions in much of today's world.

Perhaps the most significant of these dilemmas stems from the emphasis on official sanction and resultant accountability within modern health care, especially in what J. P. Gone and Alcántara (2007) labeled the “therapeutic triad” in clinical activities involving mental health professionals:

This rationale [of accountability] applies to professional interactions involving what we designate as the “therapeutic triad,” in which *credentialed clinicians* provide *costly services* to *vulnerable clients* suffering from clinically significant psychological impairment or distress. The therapeutic triad recognizes that clinicians are *credentialed* (usually through master's or doctoral level training in accredited programs, plus professional licensure in the state in which they practice) precisely because they provide professional services that presumably require expertise beyond the facility of the general public to evaluate independently. In such instances, the philosophy of “caveat emptor” is trumped by the quality control efforts of relevant civic and professional bodies. Furthermore, these expert professional services are understood

to be relatively scarce and, therefore, *costly*. Indeed, the majority of individuals experiencing diagnosable psychological distress in their lifetimes do not obtain specialized mental health treatment for their problems, owing in part to the limited availability and high cost of these services. Finally, persons who obtain such services typically contend with rather serious psychological disruptions in their lives and livelihoods. If ever individuals are in need of quality control and assurance to inspire their trust, bolster their confidence, and protect their interests, it is in these particularly *vulnerable* moments when sometimes even life and liberty are at stake. Thus, in instances properly characterized by the therapeutic triad, the professional obligation to provide the most effective therapeutic services available would seem beyond controversy or dispute. (p. 357)

Certainly, conditions defining the therapeutic triad—*expertise*, *scarcity*, and *vulnerability*—are further exacerbated by the infinite insufficiency of psychotherapeutic resources in Indian country (J. P. Gone, 2003, 2004b), which at least implies that the measures for assuring efficacy should become more stringent as well. In other words, once *any* given therapeutic approach is incorporated into the health care establishment, in which there is simply not enough effective intervention to go around, its proponents become obligated to play by the rules that invite and require professional scrutiny and public accountability. In short, the price of admission to institutionalized health care is *surveillance*. As a result, nontrivial incorporation of the constituents of Native traditional healing into the practice of modern psychotherapy will essentially bring formerly suppressed indigenous religious customs and claims (Anderson & Gone, in press) under the surveillance of health care bureaucracies and institutions. Such surveillance retains the alarming potential for reproducing the historical injuries of Euro-American colonization.

In light of the political sensitivities surrounding religious sensibility and practice within contemporary Native communities as well as the institutional constraints that circumscribe the activities of many health care service providers, the future development and provision of integrative psychotherapy for American Indians (and, by extension, other ethnoracial minorities as well) will encounter substantive practical challenges.

Substantive Practical Challenges

There are at least four kinds of challenges that will confront any systematic effort to integrate traditional healing into professional psychotherapy for

contemporary American Indian clients. These challenges emerge primarily from the postcolonial circumstances in which such healing traditions have survived as well as the cultural divergences in epistemology, context, and practice already described in this article. Although contemporary instantiations of American Indian healing tradition may differ from the historical paradigm represented and expressed by Bull Lodge in significant ways, these nevertheless will present counseling psychologists with practical difficulties requiring political and cultural sensitivity. Such difficulties include substantive problems pertaining to the description, translation, integration, and evaluation of traditional healing practices, respectively.

Description. Despite the existence of a small (but increasing) literature on American Indian traditional healing relative to psychotherapy specifically and to institutionalized health care services more generally, it is in fact almost impossible to find detailed descriptions of what traditional healing in many of these settings might actually entail. Indeed, the narrative of Bull Lodge's life is rather unique in preserving the ritual details of the Gros Ventre therapeutic paradigm (Gone, 2006a); beyond even older anthropological accounts, such portrayals are extraordinarily rare. From the perspective of developing an integrative psychotherapy for American Indians, it would seem to be professionally, ethically, and fiscally necessary to learn more precisely which specific healing operations are being provided (or proposed) by what kinds of practitioners for which subsets of distressed American Indian clients. This formulaic prescription obviously echoes Gordon Paul's (1967) classic question regarding psychotherapy outcomes: "What treatment, by whom, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" The principal challenge here is that many traditional healers may be reluctant (for the reasons noted earlier) to describe their activities or predict ritual outcomes in the kind of detail that lends itself to ready therapeutic integration. This would seem especially so regarding traditional approaches that might run counter to well-established knowledge in the practices of conventional health care (e.g., recall the conclusions drawn by Levy et al., 1979). In other words, a successful integration project will need to determine what ethical and professional alternatives might serve both the needs of the healer for discretion and the needs of the integration researcher for specifiable healing routines.

Translation. Even if cogent descriptions of traditional healers' prescribed activities and targeted outcomes were readily afforded, incorporation of these into psychotherapy and the institutions of modern health care will require rearticulation of these efforts across contextual domains. That is, some portion of the healer's efforts must be approximated to the activities and interests

of professional psychologists so that decisions can be made about which kinds of traditional healing interventions ought to be supported or included and which are best left beyond the purview of psychotherapy and health interventions more generally. For example, would exorcism of a “spirit of alcoholism” *from the community* (perhaps not even involving direct intervention with any individuals struggling to control their drinking) be appropriate for integration (as in Gone, 2008c)? What about exorcism of this same spirit from a troubled individual? What about ritual use of peyote for substance abusing community members? Perhaps most important, careful attention must be devoted to translating targeted outcomes so that healers are not held accountable for results that were never promised (though the practice of traditional healing in many forms may preclude the promise of *any* precise outcomes altogether). The principal challenge here is that many traditional healers may describe their interventions in terms that require careful translation so that integration researchers might better negotiate inclusion of the most promising practices. In other words, a successful integration project will need to determine what cadre of individuals is best positioned to accomplish this kind of translation and what criteria these individuals should use in approximating diverse practices and understandings.

Integration. Once a set of traditional interventions has been described, translated, and designated for inclusion within psychotherapy and associated health care activities, the precise details of integration would have to be conceived and articulated. Issues of consultant healer selection, procedural specification, presenting problem, client attributes, counselor training, institutional resourcing, targeted outcomes, staff remuneration, and quality control relative to implementation of innovative integrations must all be addressed. Naturally, a good many of these issues are foreign to the practice of traditional healing and will require accommodation, revision, or rejection by consultant healers. The principal challenge here is that many traditional healers and integrative interventionists may object to the kinds of intrusive surveillance and regulation that would accompany the provision of their expertise within modern health care settings. In other words, a successful integration project will need to determine which of these aspects of systemic surveillance and regulation are necessary as opposed to optional with regard to inclusion of traditional healing components within an integrative psychotherapy. In addition, integrative efforts must also take care to thoroughly vet the implications of these bureaucratic requirements for forms of traditional healing so adapted.

Evaluation. The hallmark of contemporary health care is the grounding of practice in empirical evidence concerning efficacy and outcome. Increasingly within health care services, “evidence-based” practice is promoted, supported,

and even required of health care professionals, including psychologists who practice psychotherapy. As a result, it is difficult to imagine that integration of traditional healing into such services would be exempted from the requirement to demonstrate efficacy if it were to be sponsored by health care organizations or paid for by health insurance companies. Moreover, demonstrations of efficacy are likely to require evaluation using scientific designs and measures owing to the predominance of a scientific epistemology in the field. Thus, scientific evaluation of integrative psychotherapies—including components of traditional healing—relative to targeted outcomes would appear to be crucial for the sustainability of any integration effort. The principal challenge here is that many traditional healers would object to the scientific assessment of their protocols, mistrusting scientific research, rejecting a scientific epistemology, and fearing the impact of unfavorable results on their own reputations and the reputation of traditional healing more generally. In other words, a successful integration project will need to determine how integrated aspects of traditional healing might be properly evaluated in the context of modern health care and to project the impact of such evaluations for the viability of both integrated psychotherapies and the forms of traditional healing on which these are based.

Innovative Integration Approach

With regard to these substantive practical challenges, and in light of the foregoing contextual considerations, what might counseling psychologists actually *do* to advance the therapeutic integration effort for American Indian clients and other ethnoracial minority populations? In light of the many complexities already reviewed, one conclusion seems clear. The intellectual and empirical work required for the creation, implementation, evaluation, revision, and dissemination of a given counseling intervention that integrates specific forms of traditional healing and designated kinds of psychotherapy could well require a career's work! Moreover, such a career would likely entail routine freedom from the workaday obligations of professional psychologists who principally earn their livings as health service providers. For example, even though Duran (2006) demonstrated remarkable progress in developing and promoting his soul wound psychotherapy, decades of clinical work with an almost exclusively Native clientele have not permitted practical dissemination or formal evaluation of this approach. An inescapable implication is that multicultural professional psychology must recognize that substantive incorporation of traditional healing into therapeutic practice with the culturally diverse—especially by mainstream providers who see such clients only intermittently—is likely much too complex for casual adoption and

widespread dissemination. As Atkinson et al. (1993) cautioned some years ago, direct application of traditional healing methods by counseling psychologists “should be undertaken only if the counselor has been trained in the healing methods by an indigenous healer and if the counselor can honestly defer to the belief system inherent in these methods” (p. 267). Otherwise, as these authors observed, referral to an indigenous healer may be the best alternate option.

In this regard, it is not difficult to imagine why referral may be the most responsible course of action for the vast majority of counseling psychologists. Sober consideration of just one initial step toward bridging the secular–sacred divide between traditional healing and modern psychotherapy can seem disorienting enough, namely, that practitioners should be prepared to lead a designated subset of their clients in *prayer*. This is what Bull Lodge did. This is what Duran does. Moreover, it seems that a majority of psychotherapists endorses and expresses personal spirituality (D. P. Smith & Orlinsky, 2004), and spiritually oriented psychotherapies are increasing in popularity (T. B. Smith, Bartz, & Richards, 2007). And yet the ethics, politics, and pragmatics of praying in psychotherapy—and especially of *guiding* clients in prayer—have not been well developed. As was made plain earlier, when it comes to the even more substantive constituents of traditional healing, the basic inaugural step—*careful description* of potentially relevant practices—has yet to be taken in any far-reaching manner in the psychological literature. In light of the rudimentary disciplinary status of such integrative efforts, it is perhaps time to move beyond breezy commendations of incorporating traditional healing when counseling the culturally different. Indeed, one significant lesson afforded by this article might simply be that professional psychology would do well to rein in its expectation to be all things to all people with regard to the meeting of psychosocial needs.

Of course, the clearest avenue of retreat in the face of such complexity leads back to the familiar, the well established, or even the “empirically supported” psychotherapeutic interventions that have yet to be evaluated for ethnoracial minority populations. Such interventions might thus be tweaked and tuned for cultural resonance with some targeted ethnoracial minority constituency (G. C. N. Hall, 2001; Whaley & Davis, 2007). Unfortunately, to proceed in this fashion (i.e., stitch some beads here, tie some feathers there) is to abandon—and perhaps even to repudiate—the most compelling critique of the multicultural movement within professional psychology. Specifically, this critique asserts in rather compelling terms that the attributes and activities of conventional psychotherapy are in fact potentially alienating, assimilating, and otherwise oppressive for historically marginalized peoples.

Instead, if multicultural professional psychology is to advance and protect the cause of American Indian clients (among others), it must continue to sound the sober call for substantive alternatives to therapy as usual (Gone, 2008a). In the context of Native North America, such alternatives will most likely emerge from collaborative projects that facilitate what Duran (2006) referred to as the *decolonization process* (also see Wilson & Yellow Bird, 2005).

Therapeutic integration as decolonization. Decolonization is simply the intentional, reflective, and communal self-examination undertaken by Native (and other formerly colonized) peoples in service to collective action that finds continuity with the “traditional” (precolonial) past even as it charts a purposeful, distinctive, and self-determined (postcolonial) future. The framework of decolonization is ideally suited to addressing the interrelated concerns that conventional psychotherapy raises for Native communities. Throughout this article, reference has been made to four implicit sources of concern that might be productively engaged by a decolonization agenda. The first is the problem of cultural assimilation posed by forms of psychotherapy practiced in Indian country that presume Western forms of subjectivity and displace local remnants of indigenous tradition. The second is the problem of creative rearticulation of precolonial indigenous therapeutic practice that must now accommodate the postcolonial distress of contemporary Native peoples in an era of rampant psychological mindedness. The third is the problem of mainstream legitimacy for these rearticulated indigenous healing traditions relative to Western health care such that access to governmental and institutional resources might be harnessed in support of therapeutic self-determination. The fourth is the problem of communal intervention that must remedy collective and enduring disruptions in identity, purpose, and way of life above and beyond the personal problems of individual Native people. In his signature decolonization effort, Duran (2006) is to be commended for the degree to which he tackled all of these problems simultaneously (e.g., publishing a book about his approach as part of a professional series, orchestrating a “liberatory” heightening of consciousness with his patients, centering identity as a fundamental therapeutic problem, etc.).

Nevertheless, Duran (2006) has labored primarily as a clinician, earning his livelihood in practice and consultation for the Indian Health Service (or for federally funded tribal health care systems) in which individual psychotherapy remains the modality of choice. In consequence, a principal limitation of his culturally specific psychotherapy is that it remains perhaps too distinctively his own (especially insofar as the approach reflects his rather idiosyncratic spiritual experiences and religious beliefs). Indeed, the ideal

alternative to Duran's soul wound psychotherapy may well be a more collaborative undertaking that engages and articulates a more collective vision for a culturally grounded "counseling" approach that, at least initially, is developed by and for a single populous Native people (or, perhaps, by and for a handful of culturally related Native peoples). Moreover, rather than one or more conventional psychotherapies remaining the implicit points of departure, "traditional" notions of wellness, distress, healing, self, personhood, emotion, social relations, and spirituality—in short, a historical Native *ethnopsychology* with its attendant therapeutic paradigm—could serve as an alternative point of departure for formulating such an approach. In this important inversion of the integrative project, energy and attention are redirected from considerations of how best to "Indianize" mainstream approaches to considerations of how best to tailor indigenous approaches to the constraints of modern health care and human services settings.

Cultivating an integration partnership. In pursuit of such an inverted integrative project, the author has recently approached two northern plains tribal communities with just such a proposal, and a tentative collaboration to formulate a culturally grounded counseling approach appears to be underway. There is not space in this venue to adequately detail this effort, but a handful of historically Algonquian-speaking peoples from the northern plains (similar in many cultural respects to the Gros Ventres) were considered candidates for collaboration. Interest in culture and counseling in these communities is most likely to find resonance with established "cultural committees" and functioning substance abuse treatment programs. Tribally controlled chemical dependency treatment centers—typically funded by the Indian Health Service but administered by tribal governments—represent especially appropriate potential partners because most of these programs already operate with somewhat greater independence from the usual institutional regimens of health service agencies. Moreover, owing to the centrality of spirituality in dominant approaches to substance abuse treatment, such centers already strive to integrate contemporary Western therapies with a variety of indigenous cultural practices, including ceremonial ones. However, monolithic ideological and structural forces conspire to ensure that typical efforts at such integration continue to resemble "mainstream" substance abuse treatment in important ways (Prussing, 2008; for case illustrations, see Gone, 2008a, 2008c, 2008d).

Thus far, the embracing of tribal ethnopsychology and therapeutic practice as the point of departure for a novel integrative counseling approach has met with remarkable enthusiasm. There remains, of course, a great deal of work to be undertaken if this "culture and wellness demonstration project" is

to achieve any success. First and foremost, project success will require an open, vibrant, and respectful collaboration toward the following objectives: (a) demonstration of the promise of a tribally specific counseling approach that promotes wellness in the distinctive cultural terms of a northern plains reservation community and (b) documentation of project processes and outcomes through tribal and research publications for the benefit of professionals, researchers, policy makers, and other tribal communities. Thus, a target problem must be collaboratively designated (probably alcohol abuse). A target population must be collaboratively identified (probably late adolescent tribal members). Most centrally, the intervention itself must be collaboratively crafted and potential "counselors" recruited and trained. Research funding will be pursued to undertake several years of developing, piloting, evaluating, and refining a culturally distinctive intervention. This process overtly seeks to recover and reclaim indigenous therapeutic practices and understandings of wellness in the formulation of a modern counseling approach for tribal members in distress. At the outset, an entire year of this collaborative endeavor might be devoted to (a) documenting and analyzing all that is presently known about the historical ethnopsychological and therapeutic traditions of the community (which are likely to resemble the therapeutic paradigm of Bull Lodge in many respects) and (b) tracing, translating, and updating such traditions for the conditions—psychological, social, spiritual, economic, and otherwise—of contemporary reservation life. Additional time will be necessary near the conclusion of the project to determine whether and how to offer the approach for use in other tribal communities or among other kinds of practitioners.

Embracing an alternative ethics. In recognition of the centrality of a *relational* ethics (Fisher, 2006) to the decolonization process, all project activities will be undertaken through partnership between cultural authorities, ceremonial leaders, treatment providers, program participants, and outside researchers. Such generative partnerships have long been promoted by community psychologists (Nelson & Prilleltensky, 2005; Rappaport, 1987; Zimmerman, 2000) and, more recently, by public health researchers (Israel, Eng, Schulz, & Parker, 2005; Minkler & Wallerstein, 2003). Indeed, Mohatt and Blue (1982) had already commenced a similar pilot project before a shift in funding policy at the National Institute for Mental Health during the Reagan administration diverted funds away to other priorities. Clearly, in the present instance, the collaborative and empowering nature of the project partnership represents perhaps the single most significant advance of this approach relative to Duran's "poetic" efforts. In terms of the decolonization process, it is through a robust community partnership that the prospects for

community assertion and self-determination become most apparent in meeting the challenges of description, translation, integration, and evaluation already described.

With regard to description, project partners will together determine whether and how sensitive cultural understandings and practices will be represented in written project materials and associated publications, though obviously adequate (if somewhat generalized) detail will be required for the purposes of reporting and promoting the intervention. With regard to translation, project partners will together determine how to rearticulate “tradition” for a sustainable future, creatively accommodating indigenous practices emanating from the past (when experience was contoured by rank, family, gender, and social status) to the present (when, in addition to these older social factors, experience is significantly contoured by well-furnished psychological “interiors” as well). With regard to integration, project partners will together determine which aspects of indigenous ritual practice and modern counseling technique ought to be combined, addressing the question of “how much culture” in local, pragmatic, and self-determined fashion. With regard to evaluation, project partners will together determine how best to address the concerns of skeptics—both within and beyond the community—by designating desirable outcomes and incorporating appropriate assessments that might demonstrate the efficacy and viability of the intervention.

As part of the decolonization process, it is especially imperative that evaluation be undertaken in a creative and open-minded fashion. Although the scientific assessment of therapeutic outcomes is largely a professional concern, community members recognize that reportable “evidence” for claims of efficacy is important in the bid for recognition and legitimacy of traditional practices (though large-scale clinical trials are unlikely). Beyond this, however, are other worthy goals that might drive methodological advances in which the preservation of tradition (and all that such entails in terms of the transmission of distinctive cultural values, identities, subjectivities, and modes of experience) is itself recognized as a necessary and desirable outcome. In sum, substantive community involvement and engagement in the formulation of integrative approaches (in proper decolonizing fashion) exposes the particular interests of the dominant professional agenda even as it reformulates that agenda to its own ends (Gone, 2008a). As a result, it remains imperative that such integrative projects in Indian country extend well beyond the creative achievements of a single individual—no matter how ingenious, poetic, or politic—to the collective energies and efforts of community members engaged in charting a sustainable and self-determined therapeutic praxis that reflects their own distinctive strategy for hurdling the colonial abyss.

Concluding Reflections

This article explored the possibilities for integration between American Indian traditional healing and contemporary psychotherapy. Careful description and explication of historical Gros Ventre healing tradition on one hand and Eduardo Duran's (2006) culture specific psychotherapy for American Indians on the other hand afforded nuanced comparison of distinctive therapeutic paradigms. Such comparison revealed significant convergences as well as divergences between these therapeutic traditions, though divergences were perhaps more readily apparent owing to the bottom-up strategy of exegesis in which striking contrasts were quite salient. Without a doubt, Duran's innovative, integrative approach illustrates the surprising degree to which modern psychotherapeutic intervention might extend toward accommodation of American Indian traditional healing practices. Nevertheless, Duran's eclectic amalgamation of Jungian theory, Buddhist philosophy, and New Age sensibilities alongside indigenous ritual traditions ensures that the liberatory transformations he seeks to orchestrate in therapy likely socialize his Native clients into a form of "American Indian culture" that is primarily of Duran's own making. Moreover, Duran has expressed serious reservations about scientific assessment of therapeutic efficacy for his soul wound intervention, and the prospects for widespread adoption and dissemination of this culture specific approach remain extremely limited.

One lesson to emerge from the analysis undertaken in this article is the degree of difficulty likely to be encountered by counseling psychologists who undertake substantive integrations of traditional healing and modern psychotherapy. Despite routine celebrations of indigenous healing practices within the multicultural counseling literature, almost no substantive description and explication of specific forms of traditional healing and associated therapeutic paradigms have been published in high-impact venues that might actually reach and influence many multicultural advocates (and their critics) within the discipline. Proponents of culturally competent psychotherapy—whether researchers or practitioners—would benefit from additional, systematic elucidations of the underlying cultural rationales, logics, and techniques of non-Western healing traditions. Once properly explicated, these therapeutic paradigms might be fruitfully compared with the modern psychotherapies toward more substantive integration efforts in service to culturally competent practice in an increasingly globalized world. In the context of Native North America, a decolonization framework has been promoted here with an emphasis on the collective and collaborative development of integrative interventions between researchers and community members.

Evaluations of the success of such efforts will ultimately depend on both pragmatic and aesthetic judgments, but it seems unlikely that universal criteria for determining how “cultural” is “cultural enough” relative to such integrations will ever emerge in abstract terms. It is not surprising that most professional integration efforts start with conventional psychotherapy and seek to tailor mainstream approaches and techniques for diverse populations in light of traditional healing practices. Perhaps it is now time for psychologists to move in the other direction as well, namely, to start with specific forms of traditional healing and to seek to tailor these to the conventions, commitments, and concerns of workaday psychotherapists. As was previously noted, the author is presently engaged in the early stages of this sort of collaboration with a northern plains Indian community. Such efforts harbor the potential for addressing the “how cultural is cultural enough” question in local, pragmatic, and self-determining fashion for this or that specific tribal community. Regardless of the ultimate success of the present endeavor, the move from healing to counseling instead of from counseling to healing should raise additional questions and challenges for a multicultural psychology in pursuit of cultural competence in the delivery of appropriate, accessible, and effective counseling interventions.

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Notes

1. The term *other-than-human person* was coined by anthropologist Irving Hallowell (1955) in his extensive work with the indigenous Algonquian-speaking peoples of the Great Lakes area. Use of this term is adopted here to represent nonhuman beings who retain many of the properties of human personhood (cognition, language use, agency, intentionality, desire) but whose designation as “spirits” makes sense only within the culturally myopic dichotomous oppositions (e.g., natural–supernatural or spiritual–material) that prevail in much Western thought.
2. As an unpublished manuscript, *Bull Lodge's Life* is not conventionally paginated throughout its sections. Furthermore, the unredacted manuscript retains both F. P. Gone's vernacular and occasional lapses in grammar and spelling. To remain faithful to the text of the manuscript as written, however, quoted material is cited as it

actually appears in the original, and without accompanying page numbers. More detailed transcripts of this excerpt from Bull Lodge's first healing performance are available from the author on request.

3. As discussed in an earlier note, use of the term *spirit* here would reinforce the Western spiritual-material dichotomy; in addition, use of the term *life force* would reinforce Western materialist and mechanistic assumptions about the world.
4. Regrettably, there was not space here to develop one of the more obvious facets of Gros Ventre therapeutics, namely, the relationship of healing tradition to particular spaces and places within historical Gros Ventre territory (but see J. P. Gone, 2008e). What gifts might Bull Lodge have received if he had fasted on different buttes in a different region of the plains? How might he have solicited those gifts if he had lived in a region of the country without mountains? In sum, how transportable is this healing tradition?
5. Duran (2006) presents a good deal of actual case material throughout his book. The selection of this session was determined principally by the representative force of the case as well as the space limitations of this article. Although the case is distinguished in part by Duran's consideration of alcohol as "medicine," and therefore as a "spirit," readers should note that he also treats emotional problems as living entities as well, explicitly avowing that "this approach is a healing process that can be used regardless of the diagnosis" (p. 80).

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Bio

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