Psychological Services
2015, Vol. 12, No. 2, 83–91

1541-1559/15/$12.00 http://dx.doi.org/10.1037/ser0000013

The Blackfeet Indian Culture Camp: Auditioning an Alternative Indigenous Treatment for Substance Use Disorders

Joseph P. Gone
University of Michigan

Patrick E. Calf Looking
Crystal Creek Lodge, Blackfeet Nation, Browning, Montana

American Indian and Alaska Native (AIAN) communities experience alarming health disparities, including high rates of substance use disorders (SUDs). Psychological services for AIANs, including SUDs treatment, are primarily funded by the federal Indian Health Service and typically administered by tribal governments. Tribal administration of SUDs treatment programs has routinely involved either inclusion of traditional cultural practices into program activities or adaptation of conventional treatment approaches to distinctive community sensibilities. In this article, we investigate a third possibility: the collaborative, community-based development of an alternative indigenous intervention that was implemented as a form of SUDs treatment in its own right and on its own terms. Specifically, in July of 2012, we undertook a trial implementation of a seasonal cultural immersion camp based on traditional *Pikuni* Blackfeet Indian cultural practices for 4 male clients from the reservation's federally funded SUDs treatment program. Given a variety of logistical and methodological constraints, the pilot offering of the culture camp primarily served as a demonstration of "proof of concept" for this alternative indigenous intervention. In presenting and reflecting on this effort, we consider many challenges associated with alternative indigenous treatment models, especially those associated with formal outcome evaluation. Indeed, we suggest that the motivation for developing local indigenous alternatives for AIAN SUDs treatment may work at cross-purposes to the rigorous assessment of therapeutic efficacy for such interventions. Nevertheless, we conclude that these efforts afford ample opportunities for expanding the existing knowledge base concerning the delivery of community-based psychological services for AIANs.

Keywords: American Indians, SUDs treatment, cultural adaptation, outcome evaluation, spirituality and treatment

The United States is home to more than two million indigenous people who are enrolled as members of 566 federally recognized American Indian or Alaska Native (AIAN) tribal nations. These remnant and resurgent indigenous communities continue to pursue access and opportunity to vibrant futures for their descendants despite the ongoing impacts of historical subjugation and dispossession by European settlers. Indeed, endemic poverty, invidious discrimination, and intrusive disruption by outsiders have long hobbled tribal ambitions, yielding considerable casualties in the form of marginalization, distress, and despair among Native peoples. Thus, AIANs continue to contend with some of the most pronounced health disparities of any ethnoracial group in the nation (Jones, 2006). The U.S. government is ethically and legally obligated to provide for the health care needs of AIANs. Since 1955, it has done so through the federal Indian Health Service (IHS), which operates and administers hospitals, clinics, and centers for tribal communities. Increasingly since the 1990s, tribal governments have assumed direct control of these operations, with the IHS providing federal funding and a variety of administrative supports. Today, the vast majority of the health facilities funded by the IHS are run by tribes. One important contextual factor to recognize is that IHS services in general are woefully underfunded; indeed, in comparison with annual per capita health care expenditures for the U.S. population of $7,713, the IHS annually expends just $2,849 per capita (IHS, 2014). A second important contextual factor is that the majority of AIANs now live in metropolitan areas, where they usually do not have access to health care services that are funded or provided by the IHS (Duran, 2005).

AIAN health disparities include a range of behavioral health problems (Gone & Trimble, 2012), the most prevalent of which appear to be substance use disorders (SUDs; Beals et al., 2005). Although maladaptive substance use has featured in stereotypical conceptions of AIANs for as long as Europeans and Euro Americans have been writing about these communities (Leland, 1976), the epidemiological portrait of SUDs in "Indian Country" is in fact more nuanced and complex. For example, Whitesell, Beals, Big Crow, Mitchell, and Novins (2012) summarized this literature by

Joseph P. Gone, Department of Psychology, University of Michigan; Patrick E. Calf Looking, Director, Crystal Creek Lodge, Blackfeet Nation, Browning, Montana.

The research described in this article was supported by a grant through the Associate Professors Support Fund from the College of Literature, Science, and the Arts at the University of Michigan. Final revisions to this article were completed during the first author's tenure as the Katz Family Endowed Chair in Native American Studies at Montana State University in Bozeman, MT. This project was reviewed and approved by the Blackfeet Nation Institutional Review Board (Protocol #14-12).

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

observing that AIAN communities reflect both disproportionately high and disproportionately low rates of current SUDs among adult Natives, depending on the community in question. Nevertheless, lifetime rates remain alarmingly high in many indigenous communities, sometimes impacting members of nearly every extended family in these settings. As a consequence, calls for increased access to appropriate and effective SUDs treatment have been commonplace; most recently, in response to the Tribal Law and Order Act, the Indian Alcohol and Substance Abuse Interagency Coordinating Committee was created to streamline federal responses to this problem. Currently, the IHS funds over 200 SUDs treatment programs throughout Indian Country (Office of Applied Studies, 2009), the vast majority of which are directly administered by tribal governments or their designates (IHS, 2011). The structures, activities, and outcomes of these programs are not well studied, but one attribute of these programs is that they tend to serve smaller numbers of clients compared with mainstream SUDs treatment programs (McFarland, Gabriel, Bigelow, & Walker, 2006).

Perhaps the most striking feature of federally funded, tribally administered SUDs treatment services throughout Indian Country is programmatic interest in and attention to *culture*. More specifically, treatment staff—many of whom are themselves AIAN tribal members—routinely represent indigenous cultural traditions as both absent from mainstream treatment approaches and yet therapeutically beneficial for indigenous clients who pursue recovery. As a consequence, program staff have capitalized on their administrative autonomy in AIAN communities to integrate indigenous traditions with conventional treatment approaches. Legha and Novins (2012) identified two kinds of efforts by which treatment staff incorporated indigenous cultural traditions into treatment services among 18 tribal programs, namely *inclusion of traditional practices* and *adaptations of conventional approaches*. With regard to the first kind of integration, Gone (2011b) reported the adjunctive inclusion of sweat lodge ceremonies, pipe rites, tobacco offerings, talking circles, fasting camps, ritual purification, and prayer within a tribally controlled SUDs treatment program in Manitoba. With regard to the second kind of integration, Venner, Feldstein, and Tafoya (2006) adapted the evidence-based therapeutic approach known as motivational interviewing for use by AIAN counselors by including indigenous illustrations, metaphors, and case examples within the training manual. In contrast to these two kinds of cultural responsiveness, however, lies a third possibility. More specifically, rather than either including traditional practices in piecemeal fashion or adapting mainstream SUDs treatment approaches, an intriguing alternative possibility is to *develop indigenous interventions* that may contrast sharply with SUDs treatment-as-usual (Wendt & Gone, 2012).

In an earlier article (Gone & Calf Looking, 2011), we reviewed the origin, purpose, concept, and setting of the intervention described here in abstract terms only, in preparation for a hoped-for attempt at future implementation. In contrast, in this article, we report details of an actual, on-the-ground pilot implementation of a seasonal cultural immersion camp as a (rare) alternative instance of indigenous treatment for SUDs among the *Pikuni* Blackfeet Indians of Montana. Our report is structured in four sections. First, we provide a rationale for our development of the culture camp, including some necessary background information about the partnership and setting that gave rise to this indigenous intervention. Second, we offer a detailed description of the structure and activities of the culture camp based on a 2012 trial implementation. Third, we reflect on the distinctive attributes of the culture camp as an alternative indigenous form of SUDs treatment. Finally, we identify several limitations and implications of the culture camp, especially as these pertain to questions of outcome evaluation for SUDs treatment in AIAN communities and beyond. At the outset, we note that primary reliance on indigenous therapeutic principles and practices in the cultivation of local treatment alternatives for AIAN clients who struggle with SUDs is apparently unprecedented in the scientific literature (Rowan et al., 2014). Thus, our effort in piloting the Blackfeet culture camp must be recognized as preliminary in nature and exploratory in purpose. Although it has remained of interest to us since the beginning to formally evaluate intervention outcomes for camp participants, it has not been possible to do so as of yet; indeed, one lesson from this project pertains to the hidden complexity of formal evaluation for this kind of intervention. As a consequence, our aspirations in this report are modest, namely to qualitatively describe and conceptually assess an actual instance of development and deployment of an alternative indigenous treatment for SUDs in Indian Country. We do so with an eye toward future refinement of this intervention and related development of additional indigenous treatment interventions in other AIAN community settings.

Rationale for the Indigenous Treatment

In our earlier article (Gone & Calf Looking, 2011), we described the history, context, and rationale for this project in careful detail. Briefly, beginning in 2008, the first author, an academic research psychologist at the University of Michigan, and the second author, the director of the residential SUDs treatment program for the Blackfeet tribal nation of Montana, entered into an academic–community partnership to reimagine conventional treatment approaches for SUDs on the basis of *Pikuni* (Southern Piegan) cultural traditions. The *Pikuni* Blackfeet are a northern Plains Algonquian Indian people who lived the celebrated life of the equestrian bison hunter prior to their settlement on the reservation in the late 19th century. Currently, about 16,000 tribal members live on or near the 1.5 million acre reservation, where they contend with intransigent poverty and attending social ills. The treatment center, known as the Crystal Creek Lodge, is an accredited, IHS-funded integrative program (promoting a mixed Minnesota/Twelve Steps/Traditional Cultural model) in Browning, Montana, that provides residential, intensive outpatient, outpatient, continuum of care, and referral services for an exclusively Native clientele. The program serves the seven reservations in Montana and one reservation in Wyoming, as well as five urban areas within the state. Residential treatment can accommodate roughly 20 clients at a time. This treatment is based on the Twelve Steps of Alcoholics Anonymous and is structured by group participation for 30–120 days of residence. The program employs an all-Native staff, including a full-time Cultural Counselor who led a cultural traditions group and coordinated client participation in outside cultural activities prior to our collaboration. As a result of this project, the Cultural Counselor, Mr. Daniel Edwards, along with another dedicated staff member, Mr. Sheridan Ground, guided the development of the intervention on the basis of their longstanding ties with traditional keepers of Blackfeet ceremonial bundles as

well as leaders of the Blackfeet traditional society known as the Crazy Dogs. Together, these Blackfeet traditionalists pursue the preservation and revitalization of the "old Blackfeet religion."

A typical approach to tailoring psychological services for culturally diverse populations is, first, to adopt an established treatment model, and second, to adapt this model to the cultural experiences of the targeted clientele. Especially in the adaptation of evidence-based treatment approaches, care is often taken to ensure that only the surface structure of the intervention is altered (for sake of cultural "fit"), leaving the deep structure of the intervention intact (for sake of technical "fidelity;" Castro, Barrera, & Holleran Steiker, 2010). A recent review of 24 published outcome studies of SUDs treatment in Indian Country revealed that the majority of these programs did indeed include adaptations in response to cultural considerations (Greenfield & Venner, 2012). All but one of these involved alterations to the surface structure of otherwise familiar SUDs treatment activities (e.g., structured, group-based opportunities for psychoeducation, introspection, and sharing). Similarly, in a scoping study of outcomes associated with indigenous cultural interventions harnessed for the treatment of "addictions" among AIAN clients, Rowan et al. (2014) reviewed 14 published articles that documented inclusion of cultural traditions in treatment. Again, all but one described supplemental incorporation of these practices into otherwise recognizable treatment approaches. The single exception identified in both reviews was a nonrandomized comparison of group outcomes associated with participation in the sweat lodge ceremony, offered as a form of "jail-based treatment" for Navajo inmates contending with SUDs (Gossage et al., 2003). Although unreliable response rates throughout the follow-up period in this study likely compromised the ability to demonstrate statistically significant outcomes, the results indicated improvement on most measures.

It is important to note that the outcome study by Gossage et al. (2003) not only represents an unusual departure from the conventional therapeutic paradigms that feature prominently in AIAN treatment settings, but it also reflects the single best effort to evaluate the impacts of an indigenous cultural practice on SUDs for AIAN clients. We could not identify any other published studies of an indigenous cultural practice that was overtly deployed as a form of SUDs treatment in its own right and on its own terms. Given the realities of accreditation, training, and funding for SUDs treatment, it is not surprising that such efforts are rare. But rather than adapting existing mainstream interventions or supplementing these interventions with adjunctive traditional practices for AIAN clients, why might it be interesting or important to invert this typical approach to tailoring psychological services for culturally diverse populations? That is, what is the rationale or justification for, first, adopting an indigenous treatment model grounded in Native traditional therapeutic principles and practices, and second, adapting this approach to the exigencies of SUDs treatment? We suggest that the answer to this question emerges from the postcolonial condition of AIAN communities. More specifically, indigenous peoples have endured historical dispossession and subjugation by European and Euro American settlers that has extended to campaigns of legal suppression of religious practices and obligatory "civilization" toward the renunciation of supposedly primitive cultural traditions. Primary consequences of this history are the widespread legacy of anomie and demoralization that have afflicted generations of AIANs, and the contemporary indigenous commitment to cultural—and especially spiritual—renewal and revitalization that are believed to ameliorate these problems (Duran & Duran, 1995). Indeed, so commonplace is the commitment to renewed tribal traditions throughout Indian Country that indigenous human services providers who live and work in these communities frequently assert that "our culture is our treatment" with reference to mental health problems (Gone, 2013).

Insofar as the attributes of mental health problems vary between disorders, a reasonable appraisal of this sweeping claim will depend on concrete consideration of specific kinds of psychological distress. For this project, we have focused on SUDs. As Gone and Calf Looking (2011) explicated in greater detail, the assertion that indigenous traditional culture might function as SUDs treatment relies on four constituent ideas. First, as above, the "culture as treatment" (CaT) claim rests on the logical connections between colonial subjugation, cultural suppression, and resultant postcolonial anomie among AIANs on the one hand, and the presumed effectiveness of indigenous cultural participation to remedy such anomie—inclusive of its behavioral health sequelae such as SUDs—on the other hand. Second, the CaT claim depends on routine observations by indigenous community members and SUDs researchers alike that many AIANs who recover from SUDs do in fact attribute their recovery to participation in reclaimed cultural traditions such as tribal ceremonies and associated spiritual practices. Third, the CaT claim draws on the perceived potential for dramatic spiritual or existential transformations as a result of AIAN cultural participation that can radically reorient individual lives in ways that are inconsistent with maladaptive substance use (similar in some respects to perhaps more familiar instances of passionate Christian conversion). Finally, the CaT claim centers on the subsequent incorporation of AIAN participants into newfound social networks that are both incompatible with substance use and linked to the wider project of community revitalization (i.e., "nation building"). Taken together, these ideas inspire AIAN confidence in CaT, yielding one final important advantage: renewed participation in cultural traditions is more likely to avoid the surreptitious circulation of western therapeutic sensibilities within AIAN communities that can represent ongoing processes of implicit western cultural proselytization (Gone, 2008). In sum, harnessing indigenous CaT harbors the potential for resolving the "postcolonial predicament" of psychological services for AIAN communities by privileging local therapeutic paradigms in the bid to ameliorate SUDs in Indian Country (Gone, 2007).

Description of the Indigenous Treatment

As Gone and Calf Looking (2011) reported, the conceptual formulation of the Blackfeet culture camp occurred through formal consultations during the summer of 2009. The intervention was envisioned as a voluntary 4-week alternative for clients who were admitted to the Crystal Creek Lodge for residential SUDs treatment during the summer months. The camp was designed to afford client participation in a variety of activities associated with pre-reservation Blackfeet life. By "living off the land" in this way, the camp was structured to orient clients to indigenous cultural practices with which they were largely unfamiliar. Owing to careful guidance by Blackfeet traditionalists, *Pikuni* spiritual principles and practices were to remain foundational for camp activities. For more than 2 years, we were unsuccessful in obtaining funds to pilot

the camp; indeed, it was not until 2012 that the second author was fortunate to procure the necessary resources. Thus, the camp was implemented for the first time in July of 2012, albeit for a limited trial period of 12 days. On one hand, this restricted duration seemed to constrain the possibility for the intervention to serve as a standalone treatment alternative; on the other hand, the brief timeframe seemed administratively manageable for an initial attempt to simply demonstrate feasibility and "proof of concept" for this innovative indigenous alternative. Throughout this implementation effort, the camp was sponsored by the Crystal Creek Lodge and administered through a partnership between a small number of full-time program staff, several members of the Crazy Dog society (who received daily honoraria for their contributions), and additional temporary support staff (e.g., camp cooks). Owing to liability concerns, the camp was attended by program staff around the clock.

For some weeks prior to the start of camp, program staff invited prospective clients to volunteer for participation in the intervention. Several individuals expressed interest, but by the first day of camp only four Blackfeet male clients actually arrived on site. This was not completely surprising, as any new undertaking on the reservation usually does not draw wider participation until positive word about the project can spread throughout the community along the "moccasin grapevine." The camp was pitched on an acre of bottomland near Cut Bank Creek in the rolling foothills of the Rocky Mountains near the Starr School community on the reservation. This secluded area was accessible by a dirt road that traveled perhaps half a mile from the two-lane highway toward the creek. The tall grass was mown in a flat area to keep away mosquitoes prior to the delivery of camp supplies (e.g., stove, tables, tents, tools, food, and craft items). The first day was dedicated to setting up camp, including the pitching of three tepees for sleeping and one double-tepee with a central fire for group activities. Potable water and portable toilets were provided. Food and snacks were stored in a covered kitchen area, and meals were prepared by the small cooking staff. So began a daily routine. Clients awoke, breakfasted, and were transported to the treatment facility in Browning for showers as desired. By midmorning, all participants had arrived to the double tepee for the day's activities. These participants included the four clients, two to three program staff, a participant-observer (the first author), a consistent core of two to four Crazy Dog society leaders who orchestrated camp life, and an alternating cadre of additional Crazy Dogs ranging from a few to a dozen participants at any given time. Planned activities, many of which were off-site, consumed the bulk of the day until suppertime back in camp. Postdinner socializing ensued in the double-tepee until clients retired to bed.

Planned activities consisted of ritual participation, traditional skills, and other cultural activities. *Ritual participation* was structured through the pipe ceremony, sweat lodge, talking circle, and a transfer rite of the Crazy Dog society. Participation in these rituals was understood as foundational to camp experience. For example, the very first activity (once camp setup was completed by the middle of the second day) was a pipe ceremony, followed on the third day by a sweat lodge ceremony in which the entire group was involved in assembling the lodge, undertaking the ritual, and socializing afterward. *Traditional skills* included pitching the tepees, painting the lodge covers, harvesting sacred plants, picking berries, tanning hides, collecting *iniskim* (fossilized shellfish that were believed by traditionalists to be animate and powerful), and constructing ritual paraphernalia such as moccasins, rattles, hand drums, and pipes for personal prayer. *Other cultural activities* included traditional storytelling, visiting a sacred site (Chief Mountain in Glacier National Park), exploration of family genealogy, and the crafting of a "decision coin" from a deer antler to assist with difficult choices in life. The personal significance of these activities was on occasion quite profound. One client, for example, learned midway through camp that he was due in tribal court, at which time his case would be adjudicated. The case involved an altercation between the client and a law enforcement officer, with the client alleging police intimidation and harassment. Nevertheless, facing a possible sentence to the state prison, this client's anxiety and distress escalated as the court date grew closer. Around this time, the group had collected *iniskim* and the client was instructed in how to paint and pray with this traditional medicine. He prayed in this fashion until the court hearing, at which time he was informed that all charges had been dismissed. Elated at this news, the client attributed his good fortune to the potent power of the *iniskim*.

Perhaps the least tangible, but most important, attributes of the intervention pertained to the creation of a flexible, easygoing, and supportive camp ambience. First, the camp was *loosely scripted*, allowing for responsive shifts in planned activities as circumstance unfolded. For example, camp leaders had hoped to obtain permission from the tribal government to allow the group to kill, skin, and dress a bison from the reservation herd in traditional fashion. When this request was denied, an alternate activity was quickly selected from among the list of preplanned possibilities. Second, the camp was *leisurely paced*, affording a comfortable and deliberate quality to daily activities that underscored the significance of group participation. For example, some nights ended later than others, but clients were always allowed to awaken in the mornings on their own schedule. No one worried about commencing an activity out of observance of the clock, and so the day began when everyone was assembled and ready (i.e., on "Indian time"). Third, the camp was *sensitively guided*, cultivating a deep openness and respect among the clients for the knowledge and compassion of the leaders. For example, the head Crazy Dogs patiently explained, modeled, and encouraged participation in traditional activities without either assuming prior client familiarity or conveying judgments about client inexperience. Finally, the camp was *community engaged*, blurring the boundary between client status and Crazy Dog society membership. For example, on occasions such as berry picking when a group of perhaps 20 participants were engaged in an activity, it seemed that (especially for those Crazy Dogs who were less frequently involved) some were unaware of which individuals were the actual designated clients. Such leveling of status among an inclusive group of participants harbors profound possibilities for indigenous forms of SUDs treatment.

Reflections on the Indigenous Treatment

Prior to this trial implementation of the Blackfeet culture camp, we remained uncertain as to whether and how the intervention we had so carefully designed and vividly imagined could be substantively realized. Although funding constraints reduced the duration of the intervention, the implementation of the camp during July of 2012 represented an unusual opportunity to demonstrate proof of

concept for an indigenous intervention that departed quite substantially in design from the conventions of typical SUDs treatment. As a consequence of this effort, we are left with several enduring impressions. Most importantly, the camp was experienced, it seemed, as truly memorable and inspiring for everyone involved. Beyond the excitement of undertaking an interesting innovation, this enthusiasm likely originated from a deeper sense of purpose. That is, it would be difficult to overestimate the sacred and sociopolitical significance of turning to and relying on indigenous traditional principles and practices as a primary source of therapeutic recovery. In the context of a bitter postcolonial legacy, this home-grown alternative synchronized efforts to assist program clients with the broader project to advance community revitalization and self-determination. More specifically, by virtue of their participation in camp activities, treatment clients were invited to chart a new way forward in their lives that self-consciously harkened back to the Blackfeet past. In so doing, they were engaged in crafting functional contemporary identities and modes of living that were continuous with—rather than alienated from—that past. In this regard, the therapeutic solution to client problems can be seen as merely a specialized instance of what already unites Blackfeet tribal members together as a common people: the shared postcolonial obligation to fashion workable identities and modes of living that concomitantly consolidate both an honorable indigenous past and a promising indigenous future.

Two constituent features of camp life appeared to structure these processes in important ways. The first pertained to *community*. In this respect, the parallels described above between client recovery and community renewal were not merely symbolic or metaphorical in character. Rather, the opportunity to assist tribal members who are lost to SUDs in finding a new way to live literally remakes the tribal community as each individual is reoriented to prosocial contributions that collectively constitute Blackfeet revitalization. In contrast to residential treatment as usual, in which clients are secluded from the community—and even from each other behind locked sections of the building at night—the openness of camp life represented a distinctive sense of client freedom and agency within the embrace of nonprofessional, noncustodial tribal members who nevertheless remained dedicated to client support and assistance. Indeed, the leveling of status noted earlier as a function of the daily comings and goings of various Crazy Dog participants resulted from an unusually porous boundary between the commonplace activities of traditionally oriented tribal members and the cloistered routines of residential SUDs treatment clients. Such permeability between community members and treatment clients obviously refashions the conventions surrounding confidentiality of treatment, in which client privacy has typically remained paramount. In this instance, client confidentiality remained a priority, as all community members who participated in camp life were oriented and committed to protecting client privacy. Nevertheless, by virtue of camp participation, more people than usual may have become familiar with client treatment status, and we have no way of knowing how this expanded awareness might have impacted client willingness to participate. And yet, in close-knit AIAN communities, a common refrain is that participation in psychological services is rarely truly private. In this instance, no clients expressed concern about this issue. If anything, appreciation was noted for the opportunity to practice sobriety within a more naturalistic setting, the distinctive promise of which was that Crazy Dog activities would remain open to client involvement long after treatment had ended.

The second constituent feature of camp life that helped to structure client adoption of a usable Blackfeet past for a vibrant Blackfeet future was *spirituality*. As we have noted, ritual participation was the deliberate foundation of camp life. The significance and appeal of spiritual purpose and practice as grounds for refashioning a meaningful life is not at all foreign to conventional treatment for SUDs, which frequently recognizes and promotes the acknowledgment of a "higher power" (as in Alcoholics Anonymous). This concept of a higher power is deliberately abstract, accommodating a wide variety of spiritual traditions. In contrast, the culture camp was grounded in the specific understandings of "the old Blackfeet religion" as promoted by the Crazy Dog society. This instantiation of Blackfeet spirituality was deliberately cultivated by the Crazy Dogs as a contrast to various forms of Christianity that exist on the reservation, as well as to pan-Indian (usually Plains) tribal practices (and, of course, to spiritual anomie or alienation). Its significance depends in part on its role in the postcolonial project already described, but it is crucially important to recognize its perceived potency on its own terms. That is, traditional Blackfeet spirituality was based on a complex of ceremonial bundles and attending rituals that access and circulate (or "transfer") *natoji* (or the power of the Sun, the most significant other-than-human being in Blackfeet cosmology) in ways that could lead to a saturation of "Sun power" (Wissler, 1912). Such em-power-ment was clearly tied to vitality, enlivenment, and renewal in ways that render ceremonial participation a therapeutic endeavor almost by definition. The therapeutic significance of ritual participation thus stands on traditional spiritual grounds, and so one consequence of the camp experience was the potential to foreclose on religious pluralism as it exists in reservation life today. Again, we have no way of knowing how these specific religious commitments might have impacted client willingness to participate. It is worth noting, however, that traditional spirituality is less doctrinaire and proselytizing than some forms of evangelical Christian practice, and participants tended to accentuate complementarity rather than contradiction between these diverse forms of religious commitment. Once again, no clients expressed concern about the prominence of traditional spirituality (even those who were reared as Christians).

More important than our enduring impressions, however, were the postintervention reflections of the clients themselves. There is not space here to review these in other than summary fashion, but on the day preceding the end of the intervention the first author conducted private interviews with each of the four clients (lasting 34–44 min, and comprising 12–16 transcript pages) to briefly assess their experiences of camp life, including their overall assessment of the camp as a form of alternative indigenous treatment for SUDs. One somber client (aged 31), who reported that he had participated in SUDs treatment on 10 prior occasions, noted that "the difference here is they focus more on the positive aspects of life, where Alcoholics Anonymous . . . [tries] to drill it into you that you're powerless." He estimated his odds of achieving sobriety following the camp at 60/40, a nontrivial improvement from his estimate of 50/50 odds in response to conventional treatment. His overall assessment of the intervention was that "about 68%, I liked it." The remaining clients were more enthusiastic. A second client (aged 31), who was in treatment for his first time, had been

exposed to traditional Native practices in several different tribal communities over the years. With regard to the camp, he emphasized the benefit of learning Blackfeet traditions specifically, and declared that "it's been really wonderful, actually; I didn't think treatment could be like this." A third client (aged 20), who had participated in treatment twice before and was court-ordered to treatment this time (choosing the camp option), explained that "I would actually prefer this one over the other [kind of treatment]; it's more open, free, and we don't follow a strict schedule and . . . strict rules that put you in that mentality of being a child." His overall assessment was that "It's excellent . . . that's all I can say." A final client (aged 54), who had participated in treatment on three prior occasions and was court-ordered to treatment this time (again, choosing the camp option), declared that "once I got into it, it's like something changed in my life." His summary impression was that "I thank the Great Spirit that I did come out here and participate and learn; I'm glad I came here." In sum, all four clients expressed appreciation for the camp as a novel and distinctive approach to treatment for SUDs that had touched their lives in meaningful ways.

Limitations and Implications of the Indigenous Treatment

In this concluding section of the article, we trace the limitations and implications surrounding the collaborative creation and trial implementation of the Blackfeet culture camp for remedying SUDs within an AIAN community. There are several limitations associated with this report. As we have repeatedly observed, this trial implementation of the camp intervention served principally as a demonstration of proof of concept for an indigenously developed, community based alternative to conventional SUDs treatment paradigms. As a consequence, this initial effort was directed toward preliminary questions and concerns and cannot speak to primary questions of replication, efficacy, portability, and cost-effectiveness. Moreover, the duration of the intervention was comparatively brief, and the number of participating clients was strikingly few. In fact, despite the brevity of the intervention, the limited number of clients undoubtedly rendered the costs of camp implementation unsustainable unless many more clients can be recruited for future offerings. Beyond this, the recruitment process yielded male clients only, requiring future attention to the gender dynamics of participation in SUDs treatment more generally and in the alternative camp intervention in particular for members of the Blackfeet Nation. Undoubtedly, gender differences in traditional roles and ritual participation will be an integral component of such an analysis (cf. Prussing, 2011). Furthermore, although local participation in the camp intervention will remain voluntary, it will be important in future offerings to carefully analyze who does and does not volunteer for such participation in the effort to clarify which kinds of Blackfeet clients the camp can reasonably accommodate. Obviously, adjustments to the camp based on such analysis—whether for recruitment, orientation, implementation, or follow-up—might ultimately expand the pool of possible participants.

Unsurprisingly, the most pressing question for the development of indigenous alternatives to SUDs treatment-as-usual concerns their efficacy: In this case, does camp participation reliably result in recovery from SUDs for Blackfeet tribal members? This question remains of central interest to local community members, of course, but excites even greater attention and concern among health care researchers, policymakers, and many providers. Indeed, in the present era of evidence-based interventions, assurances of treatment efficacy are virtually required for broad attention, widespread legitimacy, and external funding. The usual means for demonstrating treatment efficacy entail controlled scientific evaluation of intervention outcomes. In principle, there does not appear to be any reason why virtually any kind of intervention—including indigenous alternatives for treating SUDs—might not be subject to evaluative inquiry of this kind (Gone, 2011a). Indeed, it was our initial purpose in undertaking this collaboration to formally assess the therapeutic outcomes produced by camp participation. On the basis of this trial implementation, however, we have become aware of several practical constraints that render scientific evaluation of camp outcomes a formidable task. One class of these constraints pertains to sociological challenges. For example, as we discovered, the resources available for evaluating an alternative indigenous treatment for AIANs with SUDs are scarce. The comparatively tiny population of AIANs (which means that such efforts may not "scale up" very broadly), combined with the inherent conservatism of the health sciences (which means that cultural adaptations of established evidence-based treatments are more likely to be supported), would appear to seriously constrain the evaluative prospects for these kinds of interventions. Another class of practical constraints pertains to methodological challenges. For example, it may not be possible to generate a large enough sample of treatment clients from this particular (and relatively sizable) tribal nation that can afford statistical power adequate for a fair test of the intervention. Even if a high proportion of the existing program clientele were to volunteer for camp participation, these participants must be further subdivided for purposes of random assignment to intervention and comparison conditions for rigorous evaluation, potentially resulting in negative or uninterpretable outcome findings.

The obvious rejoinder to this methodological concern would be the seemingly straightforward recommendation to implement the intervention across multiple AIAN communities to obtain an appropriately large sample of participants for random assignment to condition. This presumes, of course, that the intervention can be standardized across multiple offerings even in a single setting, but both the community's proprietary involvement and the intervention's loosely scripted structure could preclude this. More significantly, in the case of community based alternatives to conventional SUDs treatment, the primary challenge stems from the purpose of developing an indigenous treatment model in the first place, namely, the harnessing of *local* traditional principles and practices for therapeutic purposes, which may not readily generalize elsewhere. As we have seen, a noteworthy result of this approach in this case was that the Blackfeet culture camp was *virtually unrecognizable as a form of psychosocial treatment* for SUDs. Excluded from the intervention, for example, were a few familiar components: psycho-education about addiction; the instruction in skills for cognitive reframing, impulse control, or relapse prevention; or the mandate for introspective self-expression in accordance with a dominant therapeutic ethos. In short, the culture camp is constituted by a variety of interactions and activities that would seem to be distinctively Blackfeet in origin and purpose. Add to this the complications stemming from AIAN forms of traditional knowledge that appear to place a high value on firsthand personal

experience (i.e., "I pursued this activity, and it helped me") rather than abstract theoretical assertions (i.e., "research demonstrates that these activities can help"); given that the former commands greater credibility than the latter for many in Indian Country (Gone, 2012), the impatience of AIAN community partners with exacting efforts to overcome these methodological challenges is understandable. In sum, it appears that *the very postcolonial fervor that fuels the AIAN dedication to developing indigenous alternatives to treatment-as-usual in the first place may actively mitigate against the prospects for scientific evaluation of these kinds of interventions in the end*.

If so, then the trade-off between AIAN community self-determination on the one hand and assurances of treatment efficacy on the other hand presents researchers and practitioners who specialize in psychological services with a difficult dilemma: Is it more important to support the postcolonial creativity of AIAN communities in their pursuit of locally meaningful solutions to intransigent mental health problems, or instead is it more important to ensure that untested and costly interventions deployed in communities with terrific needs and scarce resources are amenable to formal and rigorous efficacy evaluation? Any answers to this query are obviously open to debate, but we tentatively suggest that divergent perspectives will vary as a function of both the degree and the target of skepticism that various constituencies bring to the overarching question of efficacy within the SUDs treatment enterprise. Beyond this, however, it may be that the apparent trade-off between local responsiveness and replicable evaluation is more illusory than real. In order to resolve this dilemma, it becomes important to reframe community interventions such as the Blackfeet culture camp as *events in complex systems* (Hawe, Shiell, & Riley, 2009). Drawing on complexity science and systems theory, this approach formulates community health interventions (and their evaluation) from an ecological perspective that accounts for the distinctive and emergent qualities of these interventions once they are implemented within specific contexts. Such qualities can include ripple effects, feedback loops, nonlinear changes in outcomes, and difficulty in disentangling attributes of the intervention from other aspects of the agency through which it is delivered or the setting in which it is offered (Shiell, Hawe, & Gold, 2008). In this regard, the Blackfeet culture camp would appear to qualify as such an intervention because it resulted from a deliberate effort to cultivate an alternative indigenous treatment for SUDs that was maximally responsive to local community conditions and concerns. The full implications of theorizing this or any other community health interventions as events in complex systems are beyond the scope of this article, but one very important implication concerns the prospects for evaluating such interventions (Hawe, Shiell, & Riley, 2004).

A central methodological challenge to intervention evaluation described earlier was that indigenous alternatives to SUDs treatment-as-usual (such as the Blackfeet culture camp) are intentionally designed to be so deeply responsive to local sensibilities that they resist standardized implementation in other communities for purposes of methodologically rigorous outcome evaluation. A systems approach to theorizing psychological services such as community-based, indigenously designed SUDs treatment, however, opens up new and exciting possibilities. More specifically, Hawe, Shiell, and Riley (2004) introduced an alternate perspective about standardization of interventions for assessment purposes, explaining that "the issue is to allow the form to be adapted [to local conditions] while standardizing the process and function" of the intervention for implementation in other settings (p. 1562). In the development of an indigenous intervention, the originating "form" of the treatment is created locally rather than externally, but the promising point for the Blackfeet culture camp is that replication in other community settings would involve adherence not to *identical content and structure* (e.g., inaugurating the camp with a pipe ceremony led by three ceremonial leaders who represent the local warrior society), but instead adherence to *identical function and process*. In other words, the attributes of the indigenous intervention to be standardized for replication are identified at a higher order of abstraction, which thereby affords other AIAN communities the opportunity to both create an intervention that is truly their own and to simultaneously replicate an indigenous approach to SUDs treatment that can be evaluated together with other localized instances of the approach. Thus, for purposes of replication and evaluation, the Blackfeet culture camp may benefit from a conceptual "scaling up," in the process becoming an Indigenous Traditional Culture Camp intervention comprised of a scripted procedure that other AIAN communities can follow in creating their own localized versions of CaT for AIAN SUDs.

Again, the procedure for this broader culture camp intervention would achieve standardization not through identical form but instead through common process. Standardized steps in this process might include the following: (a) identify community partners with expertise in SUDs treatment; (b) assess interest in and applicability of various traditional cultural practices for local therapeutic promise; (c) engage local ceremonial leaders and cultural authorities in designing a therapeutic cultural immersion experience for SUDs treatment clients; (d) ensure the potential for ongoing involvement in cultural activities throughout the postintervention period of client recovery; (e) pilot the culture camp intervention for purposes of refinement prior to outcome assessment; (f) adopt process and outcome measures based on a standard evaluation protocol, but also prepare to assess locally meaningful constructs and measures (as motivated and described by Gone, 2009); (g) implement and evaluate the refined intervention; and (h) compare outcomes between intervention and control group participants irrespective of community (unless sample size affords multilevel modeling, in which case the original methodological concern was moot). Clearly, a host of additional details would need to be settled on as well, including criteria for standardizing "dose" and duration of cultural immersion, but even this brief elaboration of the potential for standardizing interventions on the basis of function rather than form begins to conceptually and methodologically address concerns about the relentlessly idiographic nature of deeply localized CaT approaches to AIAN SUDs. Importantly, Allen, Mohatt, Beehler, and Rowe (in press) recently published an exciting precedent for designing interventions in this fashion in a special issue of the *American Journal of Community Psychology* that describes their People Awakening Project. Dedicated to addressing alcohol use disorders among Alaska Natives, this collaborative project focused on prevention rather than treatment of this formidable problem by developing a comprehensive toolkit of locally and culturally meaningful intervention activities that distinctive Alaska Native communities might adopt in selective fashion. Thus, the People Awakening Project is an exemplar of inter-

vention design, implementation, and evaluation that prioritizes function and process over form and content.

In any case, when it comes to alternative indigenous interventions for SUDs within AIAN communities, there remain several areas of inquiry in need of more and better evidence, independent of the difficulties of undertaking randomized controlled trials with these approaches: Can processes linking traditional cultural participation and recovery from SUDs in AIAN communities be harnessed and deployed as treatment? Is cultural immersion truly enough to remedy SUDs for AIAN clients across a range of addiction severity? Can scientific evaluation of CaT projects overcome not just in principle but in actual practice small sample sizes, constraints on random assignment, difficulties of replication, and so forth? Can development, implementation, and evaluation of CaT projects successfully compete for research funding? Perhaps all can agree that, for each of these domains, the field needs better knowledge than it has. Moreover, across the spectrum of outcome evidence (i.e., beyond findings of randomized controlled trials), much additional inquiry is possible that will shed incremental light on these efforts. Finally, answers to all of these questions should be appraised in light of AIAN community-based opportunities to tackle SUDs through both postcolonial creativity and local self-determination. Indeed, the degree of local enthusiasm for the Blackfeet culture camp—reflected not so much in rates of client participation but rather in terms of community engagement and ownership (e.g., designing the intervention with limited guidance from the academic partner, enlisting the Crazy Dogs as camp leaders, reallocating local resources when external funding was not available, implementing the intervention years after the initial period of development)—was certainly one of the most promising aspects of our commitment to develop an alternative indigenous intervention to AIAN SUDs. We thus look forward to continuing our collaboration in pursuit of additional evidence concerning the refinement, replication, and results of the Blackfeet culture camp as an exemplar of alternative indigenous treatment for SUDs for this specific reservation setting and beyond.

Conclusion

In this article, we have presented and reflected on the trial implementation of an alternative indigenous treatment for SUDs designed specifically for clients of the Crystal Creek Lodge on the Blackfeet reservation of Montana. The difficulties in procuring funds for the Blackfeet culture camp resulted in a trial run of the intervention that was reduced in duration and offered to only a small number of clients. Nevertheless, this demonstration of proof of concept for the culture camp afforded several insights pertaining to the postcolonial formulation of indigenous alternatives to SUDs treatment-as-usual for AIAN communities. We have identified several challenges associated with these projects, especially concerning the formal evaluation of intervention outcomes, but there remain plentiful opportunities to contribute additional knowledge on the basis of further inquiry. In this regard, we close with an acknowledgment of a potentially hopeful development from beyond Indian Country that could illuminate a parallel path forward for AIAN communities, namely, the current therapeutic proliferation of the nonwestern spiritual practice of mindfulness meditation. As an increasingly prevalent component of psychological services, mindfulness meditation has generated a corpus of research evidence that has begun to address basic efficacy questions (Goyal et al., 2014). The irony is not lost on AIAN communities, however, when this increasingly cosmopolitan spiritual practice with origins in Asia arrives with some fanfare to Indian Country in association with psychological and other health care services, whereas the spiritual traditions that are indigenous to North America are casually dismissed on the grounds of questionable efficacy. Instead, we look toward the day when the spiritual practices of AIAN communities might find similarly widespread recognition and legitimacy in the treatment of SUDs within these settings.

References

Allen, J., Mohatt, G. V., Beehler, S., & Rowe, H. L. (2014). People awakening: Collaborative research to develop cultural strategies for prevention in community intervention. *American Journal of Community Psychology*. Advance online publication. doi:10.1007/s10464-014-9647-1.

Beals, J., Manson, S. M., Whitesell, N. R., Spicer, P., Novins, D. K., & Mitchell, C. M., for the AI-SUPERPFP Team. (2005). Prevalence of *DSM–IV* disorders and attendant help-seeking in 2 American Indian reservation populations. *Archives of General Psychiatry, 62,* 99–108. doi:10.1001/archpsyc.62.1.99

Castro, F. G., Barrera, M., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology, 6,* 213–239. doi:10.1146/annurev-clinpsy-033109-132032

Duran, B. M. (2005). American Indian/Alaska Native health policy. *American Journal of Public Health, 95,* 758. doi:10.2105/AJPH.95.5.758

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany, NY: State University of New York.

Gone, J. P. (2007). "We never was happy living like a Whiteman": Mental health disparities and the postcolonial predicament in American Indian communities. *American Journal of Community Psychology, 40,* 290–300.

Gone, J. P. (2008). Introduction: Mental health discourse as Western cultural proselytization. *Ethos, 36,* 310–315.

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting & Clinical Psychology, 77,* 751–762.

Gone, J. P. (2011a). Is psychological science a-cultural? *Cultural Diversity & Ethnic Minority Psychology, 17*(3), 234–242.

Gone, J. P. (2011b). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology, 47*(1–2), 187–202.

Gone, J. P. (2012). Indigenous traditional knowledge and substance abuse treatment outcomes: The problem of efficacy evaluation. *American Journal of Drug and Alcohol Abuse, 38*(5), 493–497.

Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry, 50*(5), 683–706.

Gone, J. P., & Calf Looking, P. E. (2011). American Indian culture as substance abuse treatment: Pursuing evidence for a local intervention. *Journal of Psychoactive Drugs, 43*(4), 291–296.

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, 8,* 131–160.

Gossage, J. P., Barton, L., Foster, L., Etsitty, L., LoneTree, C., Leonard, C., & May, P. A. (2003). Sweat lodge ceremonies for jail-based treatment. *Journal of Psychoactive Drugs, 35,* 33–42. doi:10.1080/02791072.2003.10399991

Goyal, M., Singh, S., Sibinga, E. M. S., Gould, N. F., Rowland-Seymour, A., Sharma, R. . . . Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-

analysis. *Journal of the American Medical Association Internal Medicine*. Advance online publication. doi:10.1001/jamainternmed.2013.13018

Greenfield, B. L., & Venner, K. L. (2012). Review of substance use disorder treatment research in Indian Country: Future directions to strive toward health equity. *The American Journal of Drug and Alcohol Abuse, 38,* 483–492. doi:10.3109/00952990.2012.702170

Hawe, P., Shiell, A., & Riley, T. (2004). Complex interventions: How "out of control" can a randomised controlled trial be? *British Medical Journal, 328,* 1561–1563. doi:10.1136/bmj.328.7455.1561

Hawe, P., Shiell, A., & Riley, T. (2009). Theorising interventions as events in systems. *American Journal of Community Psychology, 43,* 267–276. doi:10.1007/s10464-009-9229-9

Indian Health Service. (2011). *American Indian/Alaska Native national behavioral health strategic plan 2011–2015*. Retrieved from http://www.ihs.gov/behavioral/documents/AIANNationalBHStrategicPlan.pdf

Indian Health Service. (2014). *Year 2014 profile*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Profile.pdf

Jones, D. S. (2006). The persistence of American Indian health disparities. *American Journal of Public Health, 96,* 2122–2134. doi:10.2105/AJPH.2004.054262

Legha, R. K., & Novins, D. K. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska Native communities. *Psychiatric Services, 63,* 686–692. doi:10.1176/appi.ps.201100399

Leland, J. (1976). *Firewater myths: North American Indian drinking and alcohol addiction*. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

McFarland, B. H., Gabriel, R. M., Bigelow, D. A., & Walker, R. D. (2006). Organization and financing of alcohol and substance abuse programs for American Indians and Alaska Natives. *American Journal of Public Health, 96,* 1469–1477. doi:10.2105/AJPH.2004.050575

Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2009, July). *The N-SSATS report: Substance abuse treatment facilities serving American Indians and Alaska Natives*. Rockville, MD. Retrieved from http://oas.samhsa.gov/2k9/192a/192aTribalFac2k9.pdf

Prussing, E. (2011). *White man's water: The politics of sobriety in a Native American community*. Tucson, AZ: University of Arizona Press.

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., . . . Dell, C. (2014). Cultural interventions to treat addictions in indigenous populations: Findings from a scoping study. *Substance Abuse, Treatment, Prevention, & Policy, 9*. doi:10.1186/1747-597X-9-34

Shiell, A., Hawe, P., & Gold, L. (2008). Complex interventions or complex systems?: Implications for health economic evaluation. *British Medical Journal, 336,* 1281–1283. doi:10.1136/bmj.39569.510521.AD

Venner, K. L., Feldstein, S. W., & Tafoya, N. (2006). *Native American motivational interviewing: Weaving Native American and western practices—A manual for counselors in Native American communities*. Retrieved from http://www.quantumunitsed.com/materials/5722_nativeamericaandmotivationalinterviewing.pdf

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry, 49,* 206–222.

Whitesell, N. R., Beals, J., Big Crow, C., Mitchell, C. M., & Novins, D. K. (2012). Epidemiology and etiology of substance use among American Indians and Alaska Natives: Risk, protection, and implications for prevention. *The American Journal of Drug and Alcohol Abuse, 38,* 376–382. doi:10.3109/00952990.2012.694527

Wissler, C. (1912). Ceremonial bundles of the Blackfoot Indians. *Anthropological Papers of the American Museum of Natural History, VII,* 63–298.

Received February 18, 2014
Revision received June 9, 2014
Accepted August 29, 2014 ■