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ORIGINAL ARTICLE

Re-imagining mental health services for American Indian communities: Centering Indigenous perspectives

Joseph P. Gone[1,2]

[1]Department of Anthropology, Harvard University, Cambridge, Massachusetts, USA

[2]Department of Global Health and Social Medicine, Harvard Medical School, Boston, Massachusetts, USA

Correspondence

Joseph P. Gone, Department of Anthropology, Harvard University, Tozzer Anthropology Bldg, 21 Divinity Ave, Cambridge, MA 02138, USA.
Email: jgone@g.harvard.edu

Abstract

The Indigenous peoples of North America are heirs to the shattering legacy of European colonization. These brutal histories of land dispossession, military conquest, forced settlement, religious repression, and coercive assimilation have robbed American Indian communities of their economies, lifeways, and sources of meaning and significance in the world. The predictable consequence has been an epidemic of "mental health" problems such as demoralization, substance abuse, violence, and suicide within these communities. One apparent solution would seem to be the initiation or expansion of mental health services to better reach American Indian clients. And yet, conventional mental health services such as counseling and psychotherapy depend on assumptions and aspirations that may not fit well with American Indian cultural sensibilities. For example, counseling practices draw on the presumed value for clients of introspective and expressive "self talk," whereas Indigenous community norms may emphasize communicative caution outside of interactions with intimate kin, leading to marked reticence rather than candid disclosure. Moreover, given community sensitivities to salient histories of colonization, such differences have the potential to further alienate American Indian community members from the very services and providers designated to help them. In this article, I review a postcolonial predicament that bedevils American Indian community mental health services and trace a program of research that has sought to harness American Indian cultural and spiritual traditions for reimagining helping services in a manner that truly centers Indigenous perspectives.

KEYWORDS

American Indians, community mental health, cultural psychology, culture-as-treatment, therapy culture

Highlights

- American Indian communities suffer from inequities in addiction, trauma, and suicide.
- These inequities originated in histories of colonization and represent postcolonial pathologies.
- Mental health services depend on assumptions that may not fit those of Indigenous communities.
- American Indian communities would benefit from unprecedented innovations in helping services.
- Innovations in helping services may depend on Indigenous cultural and spiritual traditions.

OPENING

I was first introduced to the transformative disciplinary legacy of Seymour B. Sarason (1919–2010) in the mid-1990s during my graduate training in clinical-community psychology at the University of Illinois at Urbana-Champaign. Sarason, I then learned, had become disenchanted with the professional myopia of clinical psychology. He disputed the presumption that the problems of individuals required treatment as individuals. He abandoned the university-based laboratory to engage people as they lived in real-world community settings (Grimes, 2010). Some of his signature publications attest to these commitments even in their titles: *Psychology in Community Settings* (Sarason et al., 1966), *The Creation of Settings and the Future Societies* (Sarason, 1972), and *The Psychological Sense of Community* (Sarason, 1974). Although I had chosen to pursue my doctorate in clinical psychology to ultimately address the "mental health" problems of American Indian reservation communities, these electrifying ideas animated an alternative vision for how I might best contribute to Indigenous community well-being and futurity. As a clinically trained, community-engaged, and culturally attuned psychologist, I realized that an academic appointment as an action researcher might afford greater opportunities for me to think and work outside of the delimiting realm of professional practice as a credentialed health service provider.

My own burgeoning commitment to exploring the fraught intersection of culture, coloniality, and mental health in American Indian communities led to interdisciplinary inquiry into Indigenous psychologies and cross-cultural helping interventions. I never dreamed, of course, that I would follow in the path of my academic father, Julian Rappaport (and his academic father, Emory L. Cowan), in receiving the award named in Sarason's honor. I am indebted to other Sarason award winners as well—Jim Kelly, Rhona Weinstein, Ed Seidman, Ed Trickett, Brinton Lykes, and Isaac Prilleltensky—for their advocacy and support along the way, not to mention, of course, the many other community psychologists and, indeed, community partners that made my career possible throughout these past nearly three decades. On this reflective occasion, I have four goals in mind for this article. First, I review a postcolonial predicament that vexes mental health services for American Indian and other Indigenous communities. Second, I consider various community-based approaches to "mental health" problems that harness American Indian "culture as treatment" for resolving this predicament. Third, I assess the strengths and limitations of these diverse approaches relative to issues of cultural commensurability. Finally, I grapple with the challenges that face these kinds of projects in the era of professional accountability and evidence-based practice.

ROUND ONE: THE POSTCOLONIAL PREDICAMENT

Early in my career, in consonance with increasing ethnoracial diversity in the United States, multicultural psychologists were critiquing the "monocultural" bias of disciplinary inquiry and professional practice (D. W. Sue, 1981). The principal concern of these critics was that mainstream mental health approaches emerged from the experiences of Europeans and Euro-Americans, and thus remained potentially alienating, assimilating, or otherwise injurious for minoritized populations (Wendt et al., 2015). One result of this critique was widespread acceptance of the importance of what has been termed *cultural competence* in clinical practice with non-White clients. Culturally competent clinical practice has been formulated in various ways (S. Sue et al., 2009), but the predominant approach conceived of culturally responsive treatment as deriving from specialized knowledge, attitudes, and skills that allow psychologists to tailor conventional therapeutic techniques to the lives of the "culturally different." The goal of such tailoring is to facilitate effective therapeutic change, while protecting the distinctive cultural orientations of these clients. Calls to cultural competence in clinical practice have stressed the importance of overcoming language barriers, recalibrating interpersonal styles, tracing the therapeutic implications of divergent cultural norms and identities, and expanding therapeutic attention to the location of clients within family and community contexts (D. W. Sue, 2001).

American Indians have received interest from multicultural psychologists as one of a handful of consistently recognized non-White constituencies in the United States. Indeed, "Indian Country" affords unique opportunities for exploring both the premise and the promise of multicultural professional psychology. The premise of multicultural professional psychology—that American Indians might be alienated by conventional clinical practice—is supported by widely shared Indigenous experiences of Euro-American colonization even though great diversity in American Indian language, religion, history, and culture endures today across hundreds of Indigenous societies. The promise of multicultural professional psychology—that American Indians would benefit from culturally tailored therapeutic interventions—is supported by widely circulating efforts to "Indigenize" treatment and recovery, whether through the Red Road to Wellbriety (White Bison, Inc., 2002), "soul wound" psychotherapy (Duran, 2019), or incorporation of Indigenous cultural traditions within addiction treatment programs that are tribally administered (Hall, 1985). As a result, treatment for psychological distress in American Indian communities remains an extraordinarily complex challenge for the multicultural mental health endeavor. Progress in meeting this challenge may well generate solutions that could generalize to the similarly complex mental health predicaments of other ethnoracial groups.

A formative project near the outset of my career entailed investigation of the connection between culture,

drinking, and depression on my home reservation in Montana (Gone, 2007, 2008b, 2019, in press-b). For two summers, I held at bay my own professional training to ethnographically explore local discourses of "mental health" among reservation respondents, with specific interest in the experience and expression of distress, the description of local healing resources, and the identification of especially promising points of intervention. I consulted with reservation policy-makers, health services providers, human services educators, spiritual leaders, and individuals with first-hand experience coping with serious personal distress. My analyses from this study have appeared in multiple publications, in part because of the significance of the lessons I drew from this early research. Specifically, in my interview with a tribal traditionalist named Traveling-Thunder, I explicated a plaintive discourse of distress (i.e., an "explanatory model," in medical anthropology terms), which seriously complicates prevailing notions of cultural competence in the mental health professions. As I have described elsewhere, Traveling-Thunder identified four historical epochs surrounding American Indian experiences of colonial subjugation, observing that epidemic mental health problems are the direct result of postcolonial anomie and disrupted ceremonial tradition. Importantly, Traveling-Thunder identified White reservation-based clinicians as engaged in deeply suspect ideological work with their American Indian patients; indeed, he referred to mental health services as "brainwashing."

In sum, Traveling-Thunder rejected the treatments on offer through the reservation's mental health program, conveying instead the promise of Indigenous sacred and ceremonial practice as a preferred form of help-seeking for reservation residents (Gone, 2007, 2008b). That is, he deemed health and help as more likely to result from Indigenous traditional religious activities (Anderson & Gone, 2009) than from modern psychiatric services (Gone, 2008a). It is here that the limits of cultural competence become apparent, as no expansion of clinician knowledge, attitudes, and skills can transform secular psychotherapeutic treatment into a sacred encounter with nonhuman *persons* who possess *power* to circulate *life* (Gone, 2019, 2021a). Such divergences in problem identification and associated help-seeking observed by American Indians like Traveling-Thunder reveal a *postcolonial predicament* that has long bedeviled mental health services in Indian Country (Gone, in press-b). On one hand, enduring disparities in mental health problems (including addiction, trauma, and suicide; see Gone & Trimble, 2012) underscore the need for more and better mental health services in our communities. On the other hand, conventional psychosocial approaches to mental health treatment depend on concepts, categories, principles, and practices that are routinely identified by community-based authorities as culturally foreign and experientially irrelevant for many (although not all) American Indians. A chief consequence of this predicament is that *American Indian communities may well benefit from unprecedented innovations in psychosocial helping services that have yet to be fully explored, designed, implemented, and evaluated.*

How then might mental health advocates, professionals, and researchers with a stake in contemporary American Indian well-being proceed to formulate, evaluate, and establish alternative, locally grounded, and culturally resonant mental health services that draw on Indigenous therapeutic traditions? And how might they do so in a manner that, first, ensures professional accountability relative to questions of efficacy (by assessing treatment outcomes) and that, second, alters longstanding relations of sociopolitical dominance by Euro-Americans (through renouncing further colonial injury)? I have dedicated my career thus far to engaging these questions through multiple research partnerships with American Indian communities over the past 27 years. During this time, my students and I have aspired to harness disciplinary knowledge practices for productively engaging some of the nation's most difficult healthcare dilemmas, including cultural inclusiveness, socioeconomic inequality, political marginality, alternative medicine, and community resilience, all in the context of Indigenous mental health concerns. One reaction by American Indian mental health experts and gatekeepers to efforts to disseminate mainstream mental health interventions—including evidence-based or empirically supported treatments—to our communities has been a stated reluctance or resistance to adopting these approaches. Indeed, I have repeatedly encountered across different tribal communities the assertion that, "we already know what works for our communities," and that "our culture is our treatment" (Gone & Alcántara, 2007; Gone & Calf Looking, 2011; Pomerville & Gone, 2019).

This alternative Indigenous culture-as-treatment claim emerges from community convictions and concerns akin to Traveling-Thunder's hesitancy to endorse and embrace conventional mental health services. In contrast to evidence-based practice, such American Indian community advocates instead promote *practice-based evidence* by championing therapeutic alternatives based on (reclaimed) Indigenous traditional practices (Echo-Hawk, 2011). Such practices frequently entail a holistic rationale grounded primarily in spirituality and religious experience. Moreover, these Indigenous practices often concurrently address not only personal distress and suffering, but also enhancement of cultural identity and even community-wide renewal and self-determination. In the remainder of this article, I review three successive community-engaged research projects that begin to address the postcolonial predicament for Indigenous community mental health services. First, I will explicate processes of therapeutic integration of both "Western" and "Indigenous" approaches that I observed at a First Nations community treatment center in Manitoba, Canada, during 2003–2004. Then, I will review the development of the Blackfeet Culture Camp in partnership with the residential addiction treatment center in the Blackfeet Nation of Montana between 2008 and 2012. Finally, I will describe the collaborative design

and pilot implementation of the Urban American Indian Traditional Spirituality Program with the urban American Indian health clinic in Detroit in 2009–2016. Throughout this review, I will highlight the lessons learned and insights gleaned from these projects, tracing the implications for reimagining Indigenous community mental health services.

ROUND TWO: THERAPEUTIC INTEGRATION IN INDIGENOUS-CONTROLLED TREATMENT

In good community psychology fashion, my next effort to engage the postcolonial predicament entailed another collaborative project undertaken in partnership with a First Nations-controlled addiction treatment program on a Cree reserve in Manitoba, Canada (Gone, 2008c, 2009, 2011). In recognition that clinical intervention inevitably and inherently entails cultural prescription, I was especially interested in the overt commitment by administrators and staff at the outpatient *Pisimweyapiy* Counselling Centre (PCC) to integrate both "Western" and Indigenous therapeutic traditions in their treatment of clients from the reserve. The PCC was one program within the larger treatment facility. The entire "Medicine Lodge" was band-controlled, tribally staffed, and regionally accredited. The explicit goals of the PCC were to provide the following: (a) "a resourceful community healing place that maintains our tribal language, culture, and spirituality;" (b) "purposefully designed and culturally appropriate community therapeutic support services;" and (c) "an integrated and holistic therapeutic approach to healing and wellness for individuals, families, and the community utilizing Western and Aboriginal practices" (Gone, 2008c, p. 133). This exploration of therapeutic integration in a tribally controlled program promised to illuminate the innovative synthesis of counseling approaches and practices that were tailored by Indigenous people for Indigenous people in the context of outpatient, community-oriented addictions treatment. Thus, I anticipated that lessons drawn from this inquiry would illuminate possible resolutions to the postcolonial predicament—i.e., disproportionately high community prevalence of some mental health problems vis-à-vis culturally incongruent and ideologically suspect helping services—which emerged from my initial work with Traveling-Thunder.

As a clinical ethnography (cf., Hartmann et al., 2018, 2020), this inquiry depended on seven weeks of on-site participant observation during 2003–2004, including open-ended interviews with 19 program administrators, counselors, and former treatment clients from the reserve (Gone, 2008c). For this project, I sought to address the following three research questions: (a) what does therapeutic practice look like in this setting? (i.e., description); (b) what does healing mean in this therapeutic context? (i.e., elucidation); and (c) what are the prospects and pitfalls of therapeutic integration in such settings? (i.e., implications). Interviews were analyzed using thematic analysis, as contextualized by additional information stemming from my immersion in the setting and my associated fieldnotes. Treatment at the PCC was designed for two phases of four weeks each, with a final week for "graduation" from the program (although this cycle was difficult to maintain as recruitment of clients tapered off following the first few years of the program). Each week required client participation in three-hour evening sessions on four nights per week. These sessions—referred to as "lectures"—involved didactic presentation of information by the counseling staff, group discussion of relevant topics, and sharing of personal experiences among clients. Besides sharing within these group sessions, clients were also regularly encouraged to meet privately with an assigned counselor for further discussion of personal matters pertaining to their recovery. Beyond their facilitation of this treatment regimen, the four counselors also scheduled routine public gatherings to facilitate healing for community members from the harmful intergenerational legacy of Canada's oppressive Indian residential schools (Gone, 2009; see also Burrage et al., 2021). Indeed, multi-year program funding was awarded to the PCC from the Aboriginal Healing Foundation in part for this broader purpose.

With respect to description of therapeutic practice at the PCC, administrators and counselors classified relevant approaches to treatment as either "Western" or "Aboriginal" (Gone, 2008c). The foundational Western treatment approach was locally identified as the Twelve Steps of Alcoholics Anonymous. This approach was lauded for its longstanding contribution to affording personal recovery from addiction. Beyond this familiar component, however, the counseling staff expressed enthusiasm for a variety of other Western therapeutic approaches: acupuncture, anger discharge, energy work, genogram mapping, grief exercises, guided imagery, inner child explorations, meditation and visualization, relaxation training, Reiki, and neurolinguistic programming. Not all of these had been actively adopted into treatment at that time, but counselor interest in these (globally circulating) forms of complementary and alternative therapies (or integrative medicine) appeared to be driven by the appeal of a diverse (sometimes non-Western) spirituality. In contrast, there was a complete absence of interest in or inclusion of "evidence-based" treatments for substance abuse (cf. Gone, 2012). Rather, these Western approaches emerged from conventional substance-abuse treatment, self-help, popular psychology, and New Age healing practices. Beyond these, the Aboriginal treatment approaches in the program included widespread Indigenous therapeutic traditions: talking circles, smudging (i.e., ritual burning of sacred plants), blessing rites, tobacco offerings, pipe ceremonies, sweat lodge ceremonies, and seasonal fasting camps. These approaches were institutionalized into the treatment program. For example, sweat lodge ceremonies were conducted on-site for clients by the facility's cultural counselor every Thursday afternoon. In addition, some counselors were pipe carriers. Client participation in these Aboriginal activities was voluntary but encouraged.

This eclectic variety of treatment approaches at the PCC raised the question of how a coherent client treatment plan might be assembled from this diverse array of (spiritually grounded) therapeutic options. The answer was staff adoption and promotion in treatment of the conceptual model of the Medicine Wheel (Gone, 2008c). The iconic Indigenous Medicine Wheel is a circle that is bisected by two perpendicular lines, which demarcate four quadrants within the circle's interior. Indigenous descriptions of the Medicine Wheel emphasize its spatial representation of four-in-one, with the prototype being the four sacred cardinal directions. Each quadrant of the Medicine Wheel is associated with a distinctive component of some larger whole, including (by extension) the four sacred colors, the four sacred plant medicines, and so forth. Additionally, Indigenous descriptions of the Medicine Wheel emphasize its temporal representation of cyclical time by tracing around the circle's circumference, with the prototype being the four seasons of the year. Overall, the Medicine Wheel is understood as a symbol of holism that represents balance and harmony among four constituent elements. In PCC treatment, the Medicine Wheel was applied to human psychology, with the four quadrants depicting a topography of the human person (mind, body, spirit, and emotion) and the circumference affording a rendering of the human lifespan (childhood, adolescence, adulthood, and eldership, with the cyclical aspect emphasizing total helplessness and dependency on others as one both enters and departs this life). PCC treatment was designed to facilitate a process of recovery that was thus dependent on pursuing balance among the mental, physical, spiritual, and emotional aspects of the self. This could be achieved by selectively adopting any of the available therapeutic approaches so long as one comprehensively attended to all facets of the person.

With respect to elucidation of therapeutic practice at the PCC, the meaning of healing became clear through observations and explanations of therapeutic discourse and activity provided by both staff and clients in the program (Gone, 2008c). In response to overt questioning, healing was explicitly characterized by program participants as the spiritual (or existential) transformations that link imperfect selves to a higher purpose. Moreover, in this Indigenous setting, such transformations necessarily included a postcolonial reclamation of robustly positive Indigenous cultural identity, which was recognized as crucial for remedying the longstanding denigration of Indigenous people in Canadian society as backward savages (with the logics of the Indian residential school system epitomizing such ethnocentric prejudice). And yet, the meaning of healing also referred to an implicit rationale—which no one participant ever fully summarized—concerning emotional burdens, cathartic expression, and self-as-project introspection. First, clients were understood to carry *emotional burdens* stemming from unexpressed pain from their past, which was believed to undermine present-day functioning. Second, treatment was presumed to depend on *cathartic expression* in which this unexpressed pain is "released" through verbal communication of past ordeals in group sessions or private counseling. Although personally aversive for most clients, such expressive disclosures were deemed necessary for eventual restoration to wellness. Finally, effective treatment was conceived as initiating modalities of *self-as-project introspection* in which lifelong practices of self-examination, self-awareness, and "working on" oneself operate to maintain wellness. The therapeutic process comprising these features was locally described as the "healing journey."

In sum, based on these explicit and implicit attributes, the meaning of healing at the PCC became clear: "Fueled by introspection, reflexivity, insight, disclosure, catharsis, dealing with one's problems, working on oneself, and finding one's purpose as an Aboriginal person," healing entailed "an ongoing process of positive self-transformation that ultimately reoriented fragile and sometimes damaged selves toward a more meaningful and compelling engagement in the world" (Gone, 2008c, p. 195). Importantly, such healing entailed a buttressing of Indigenous identity for PCC clients. Moreover, the therapeutic activities of the PCC staff extended beyond client transformation proper to bridging individuals and the community, as counselors promoted this therapeutic discourse in public gatherings dedicated to healing from the shared legacy of the Indian residential schools. With respect to the implications of this analysis for therapeutic integration in Indigenous-controlled treatment settings, one insight is worth highlighting here. The therapeutic rationale for treatment at the PCC depended centrally on verbal disclosure by clients of personal pain in the therapeutic setting (i.e., "the talking cure"). This is a recognizable feature of *therapy culture* (Furedi, 2004; cf. Gone, 2021c), which refers not so much to the norms and routines of the professional practice of psychotherapy but rather to a wider set of logics and discourses that proliferate through self-help groups, popular psychology, and global media to broader society. In short, even with an intentional institutional commitment to the integration of Western and Aboriginal treatment approaches, the rationale for healing at the PCC retained at its core certain identifiable tenets of modern, globalized therapy culture.

In and of itself, there is nothing wrong with the promotion of core facets of therapy culture (e.g., the expectation that Indigenous clients must "disclose" painful childhood experiences to nonintimates during group treatment sessions in an emotionally cathartic manner) within Indigenous-controlled treatment settings. Indeed, Indigenous people have adopted and adapted the tools and technologies of modernity since the first European contact. In this instance, however, it was striking how few of the PCC clients persisted in treatment through the graduation phase (Gone, 2008c). I speculated that one explanation for this notable fall-off in treatment participation pertained to stark divergences in communicative norms associated with the treatment setting and the broader community, respectively (Prussing & Gone, 2011). Such divergences became apparent through my interviews in which both counselors and clients talked about talk: counselors recounted the

challenge of getting their clients to "open up" and verbalize their pain, whereas clients talked about navigating the pressure to disclose deeply personal matters in group sessions. Thus, the mandate in treatment to verbally share personal pain to others in the therapeutic setting appeared to contrast markedly with widespread cultural norms among Crees (and among Indigenous peoples more generally), which instead prescribe taciturnity and emotional restraint when speaking with nonintimates (Darnell, 1981). This mismatch in communicative norms may well have prevented many clients from accessing therapeutic benefit in treatment. In the end, this project drew my attention to assessing the broad cultural commensurability of treatment approaches (Wendt & Gone, 2012a). Moreover, it led me to attend more carefully to the core versus peripheral attributes of such integrative therapeutic endeavors (e.g., treatment approaches that center elements of therapy culture but package these in Indigenous traditions).

ROUND THREE: CENTERING INDIGENOUS THERAPY IN THE BLACKFEET CULTURE CAMP

In my next major action-research project, I sought to overcome the potential limitations of globalized therapy culture by pursuing greater cultural commensurability with community sensibilities in American Indian mental health services. I did so by aiming to invert the usual approach to cultural adaptation of stock forms of psychotherapy. Typically, cultural adaptation of mental health treatments starts with adopting mainstream psychotherapeutic approaches (preferably evidence-based interventions), only to secondarily adapt these for use in "diverse" community-based mental health services (Castro et al., 2010; cf. Gone, 2015). Given the lessons of the PCC, however, I decided to reach out to potential community partners with a proposal to "flip the script" for cultural adaptation: what might result, I wondered, if we started by adopting Indigenous therapeutic traditions, only to secondarily cultivate these for use as interventions in community-based mental health services? This inverted approach to cultural adaptation appears to correspond most closely to the culture-as-treatment claim I routinely encountered in various tribal communities. By way of context, it is useful to note that American Indian community members routinely characterize the mental health inequities in their midst as stemming from *historical trauma* (i.e., instances of ancestral colonial subjugation that are posited to increase the susceptibility of current descendants to mental health problems; Brave Heart et al., 2011; Gone et al., 2019; Hartmann et al., 2019). Within this problem frame, substance-use disorders are properly conceived as a postcolonial pathology within these communities.

The framing of addiction in American Indian communities as a postcolonial pathology helps to explain the intelligibility of the culture-as-treatment claim (Gone, 2013; Gone & Calf Looking, 2011). Everywhere I go in Indian Country, American Indian people routinely attribute local recovery from substance-abuse problems to participation in Indigenous cultural and ceremonial traditions. This has led to research that has found positive associations between participation in traditional cultural practices and American Indian recovery from addiction (Spicer, 2001; Torres Stone et al., 2006). The corresponding rationale for the potential efficacy of Indigenous culture-as-treatment is that postcolonial anomie (i.e., a loss of identity, purpose, place, and meaning, as identified by Traveling-Thunder) mediates the relationship between legacies of colonial subjugation and postcolonial pathologies (such as addiction, trauma, and suicide); therefore, intervening to remedy such anomie can address these problems. In sum, in the context of addiction, the culture-as-treatment hypothesis is that reclamation of Indigenous cultural practices can resolve substance abuse through personal reorientations that yield striking transformations in individual purpose, motivation, spirituality, peer associations, and social networks. To further explore the prospects for harnessing culture-as-treatment for American Indian addiction, in the spring of 2008 I initiated a dialog with staff at the Crystal Creek Lodge in Browning, MT. As an accredited residential substance-abuse treatment program administered by the Blackfeet Nation, the Lodge provided treatment for American Indian clients from throughout the region. As a Minnesota-model program (Anderson et al., 1999), the Lodge adopted treatment-as-usual based on group sessions designed to engage clients in the Twelve Steps of Alcoholics Anonymous.

In this initial dialog, I described the process for culturally adapting treatment, presented the inverted approach already described, and inquired about local interest in pursuing scientific outcome evidence for an alternative Indigenous treatment approach. The director and staff enthusiastically embraced this project, leading to more extensive consultation in August of 2009. The purpose of this consultation was to facilitate the design of an alternative approach to addiction treatment at the Lodge that would center *Pikuni* Blackfeet therapeutic tradition (Gone & Calf Looking, 2011). The cultural counselor at the lodge, Danny Edwards, and I began the process of approaching sacred bundle keepers and other religious traditionalists involved in the Blackfeet Crazy Dog Society for guidance on formulating a distinctive *Pikuni* treatment model. The result was the design of a radically alternative treatment approach: a summer cultural immersion camp designed to immerse Blackfeet addiction clients into the pre-reservation lifeways of their ancestors. This Blackfeet Culture Camp (BCC) was to be directly facilitated by grassroots, nonprofessional members of the Crazy Dog Society. A key component of the BCC was the opportunity for clients to be socialized into "the old Blackfeet religion," as practiced by the Crazy Dogs. Thus, a crucial rationale for the therapeutic promise of the BCC was religious: healing and recovery from addiction (and, indeed, other health problems) was implicitly understood to result from sacred and ceremonial practices that circulate *power* and *life* (sacred

concepts, which many Blackfeet associate with the Sun). Thus, ceremonial participation is conceived as intrinsically therapeutic (just as it was for Traveling-Thunder).

Obtaining funding for pilot implementation and evaluation of the BCC turned out to be quite challenging, and so it was not until the summer of 2012 that we proceeded with a "proof-of-concept" demonstration of the program (Gone & Calf Looking, 2015). A primary purpose of this demonstration effort was to determine whether the BCC as designed could be effectively administered in a manner that would ultimately appeal to Blackfeet treatment clients. I was able to devote some research funds to this effort, but most of the funding was contributed by the Crystal Creek Lodge, testifying to staff enthusiasm for this endeavor. Officially sponsored by the Lodge and facilitated by members of the Crazy Dog Society, the pilot program successfully recruited four Blackfeet treatment clients (all men) to participate in the two-week trial implementation (such small numbers are not unusual for novel programs being tried for the first time in American Indian settings). Activities during the BCC can be grouped into three categories. *Traditional skills* included tepee setup, lodge painting, berry picking, plant harvesting, hide tanning, and *iniskim* collecting (the latter are fossilized ammonites that are conceived by American Indians on the northern Plains as persons with power, who can bring "luck" to their bearers). *Cultural practices* included traditional storytelling, tracing family ancestry, visiting sacred sites, and engaging in a traditional decision-making exercise. *Ritual participation* included ceremonial engagement in talking circles, pipe ceremonies, the sweat lodge ritual, and a transfer rite performed by the Crazy Dog Society.

The distinctive ethos surrounding the pilot implementation of the BCC is also important to recognize (Gone & Calf Looking, 2015). First, the BCC was *leisurely paced*. In contrast to the strict regimens of addiction treatment-as-usual, daily BCC activities began once everyone was ready (occasionally as late as 10:30 a.m.) and ended once prescribed activities had concluded (occasionally as late as 11 p.m.). Second, the BCC was *loosely scripted*. The Crazy Dog leadership had identified multiple traditional activities for the two-week period, but these were incorporated flexibly in response to daily contingencies (e.g., inclement weather and availability of transportation). Third, the BCC was *sensitively guided*. Although some traditional leaders in American Indian communities can be rigid and demanding with respect to "proper" engagement in cultural activities, the Crazy Dog leaders were interpersonally warm, responsive, and nonjudgmental with clients, consistently interacting with them as patient teachers of novice learners. Fourth, the BCC was *staff-monitored*. It was crucial that trained and credentialed Lodge staff attend and monitor the activities of the BCC because clients are vulnerable during addiction treatment and the Lodge maintained ethical and legal responsibility for their welfare. Finally, the BCC was *community-engaged*. The Crazy Dog Society led and supported BCC activities, and so volunteers from the society arrived each day to assist. These volunteers came and went as their schedules allowed, and at times the number in attendance was much higher than the number of clients. Importantly, it became clear that many volunteers did not even know which participants were formal clients. This dissolution of the boundary between client and community was further articulated by participant statements that the BCC would be beneficial for any Blackfeet person, whether pursuing addiction treatment or not.

By the end of the pilot implementation of the BCC, I was left with several enduring impressions (Gone & Calf Looking, 2015). It was remarkable that this radically alternative approach to addiction treatment could come together as seamlessly as it did in actual implementation. Moreover, I found the experience of the BCC as both memorable and inspiring. Indeed, it would be difficult to overstate the sacred and sociopolitical significance of the collaborative design and implementation of this alternative Indigenous approach to addiction treatment. In addition, both the form and content of the BCC was utterly unrecognizable as psychosocial mental health "treatment." There was no invitation or instruction for psychological introspection, expressive communication, reflexive self-management, or behavioral skill-building. Rather, the BCC centered traditional spirituality and religious experience. For example, immediately after setting up camp on the first day, participants gathered for a pipe ceremony. On the second day, everyone ventured into the bush to build a sweat lodge and participate in the ceremony. Furthermore, participation in the BCC promoted a genuine sense of community and belonging, both among clients and between clients and members of the Crazy Dogs. This was important insofar as addiction clients must frequently enter new peer networks to maintain sobriety following addiction treatment. Therefore, exposure to the Crazy Dog Society during treatment ensured that clients were aware of a welcoming social network for which substance use was discouraged due to its incompatibility with ceremonial participation. Finally, based on postcamp interviews, all four clients expressed highly positive assessments of the BCC.

In the wake of this innovative effort to center American Indian therapeutic traditions in addiction treatment for the Blackfeet Nation, several crucial questions arose with respect to future research concerning Indigenous culture-as-treatment (Gone & Calf Looking, 2015). First, there are key empirical questions. Can processes linking culture and recovery in American Indian communities be harnessed and deployed as effective addiction treatment? Is cultural immersion enough to truly remedy substance-abuse problems across a range of addiction severity? Obviously, such causal questions are difficult to confidently answer in the absence of formal research designs that attempt to address questions of treatment efficacy. Moreover, full recovery from addiction is not typically inferred for treatment clients until years of stable abstinence have been achieved, which necessitates long-term follow-up assessment concerning substance-use behaviors. Second, there are key

logistical questions. Can scientific evaluation of culture-as-treatment projects overcome small sample sizes, constraints on random assignment, and so forth? Can development, implementation, and evaluation of these projects successfully compete for research funding? The very nature of locally emergent treatments that center Indigenous therapeutic traditions suggests that the possibilities for more rigorous research designs are limited, and that the awarding of major research grants from scientifically conservative funding agencies to support such inquiry is unlikely. And yet, pilot implementation of the BCC raises the intriguing possibility that there are irreducible trade-offs between the development of deeply local, community-driven interventions on one hand and the design of portable, replicable, and scientifically evaluable interventions on the other hand. In this instance, the BCC was so valued by the community that it was offered in subsequent summers even without external support.

ROUND FOUR: THE URBAN AMERICAN INDIAN TRADITIONAL SPIRITUALITY PROGRAM

In my partnership with the Blackfeet residential addiction treatment program, I learned that culture-as-treatment could entail the development of Indigenous-centered mental health treatment approaches that were so customized to a given American Indian community that the prospects for program portability and formal scientific outcome evaluation seemed unlikely (Gone & Calf Looking, 2015). In response, I wondered if there might be some middle ground between (a) American Indian community adoption of externally developed and professionally vetted mainstream interventions, and (b) American Indian community design of hyperlocal, Indigenous-centered treatment approaches. My chance to explore this third option emerged from my longstanding research partnership with the regional urban American Indian health clinic in Detroit (Gone et al., 2017, 2020; Hartmann & Gone, 2012; Wendt & Gone, 2012b, 2016). Beginning in 2009, my research team was invited by the leadership of American Indian Health and Family Services, Inc. (AIHFS), to determine how best to incorporate traditional healing practices into clinic programming. One of more than 40 Urban Indian Health Programs that serve American Indian populations in large metropolitan areas throughout the nation (Indian Health Service, 2021), AIHFS aims to "empower and enhance the physical, spiritual, emotional, and mental well-being of American Indian families and other underserved populations in southeast Michigan through culturally grounded health and family services" (Dennis et al., 2016, p. 16). It does so by offering a full range of health services to thousands of clients annually, including mental health counseling and therapy, as well as broader cultural programming for the Detroit-area American Indian community. Such commitments are common among Urban Indian Health Programs (Pomerville et al., 2022; Pomerville & Gone, 2018).

Less common is a sustained institutional focus through a community-university research partnership on creatively designing integrative services that bridge biomedical professional care and Indigenous traditional healing practices (Gone, 2010; Moorehead et al., 2015). The initial phase of this project (2009–2010) was dedicated to formal consultations with various constituencies at AIHFS to ascertain broad interest, experience, and expectation with respect to the integration of traditional healing into the health clinic (Gone et al., 2020). My research team interviewed three clinic administrators and nine service providers about these issues. In addition, we conducted four focus groups with 26 American Indian community members concerning their knowledge of and interest in traditional healing. Finally, we interviewed eight American Indian healers from throughout the region to obtain their insights about the prospects for integrating their practices into AIHFS health services. One lesson from these consultations was that many respondents were enthusiastic about incorporating traditional healing despite limited knowledge of or prior exposure to these practices. Among those that were familiar with such practices (e.g., the healers and certain staff members), opinions varied concerning the prospects for services integration, ranging from skepticism that traditional healing could be brought into the big city to the recommendation that the health clinic adopt a specific form of acupuncture. From these consultations, we identified four trade-offs that must be managed for clinical incorporation of traditional healing (e.g., enthusiasm for healing vs. anxiety about healer trustworthiness, integrity of traditional healing vs. the appeal of alternative medicine; see Hartmann & Gone, 2012). And yet, despite these illuminating consultations, a clear path forward toward the effective integration of traditional healing in this collaborative endeavor had not emerged.

During the summer of 2012, my research team met with the AIHFS leadership to review our findings from these consultations and to seek direction for the next phase of our action research (Gone et al., 2020). In preparation, we concretely identified a handful of possible projects for presentation to the leadership, including an evaluation of the clinic's culturally based youth program or the cultural adaptation of treatment in their behavioral health program. The option that met with immediate and unanimous endorsement, however, was the proposal to create an Indigenous traditional spirituality curriculum that would formally orient and introduce urban American Indian community members to these enduring religious practices. As these traditions were long subjugated by Euro-American society as part of the misguided effort to "civilize" American Indians, however, there are significant community misgivings surrounding publicization of—and especially research about—these endangered spiritual practices (Tribal Health Research Office, National Institutes of Health, 2021). Thus, we convened a Traditional Teachers Advisory Council comprising five elders at AIHFS who could provide guidance to ensure that design and evaluation of the curriculum would proceed with

utmost sensitivity and respect. This group determined that the American Indian sweat lodge ceremony would serve as an ideal foundation for organizing the curriculum, in part because the ceremony itself incorporates many components of Indigenous traditional spirituality that can also be practiced in standalone fashion (e.g., prayer, smudging, singing, and smoking). Although my late father had obtained the rights to regularly conduct sweat lodge ceremonies (Gone, 2021b), I knew that we needed concrete direction from a regional ceremonial leader for the creation of a curriculum organized around the sweat lodge. The Traditional Teachers Advisory Council recommended Paul Syrette, who agreed to assist us.

For the 2012–2013 academic year, my research team routinely consulted with Mr. Syrette to design the curriculum. The resulting Urban American Indian Traditional Spirituality Program (UAITSP) (Gone et al., 2017, 2020) was created for any interested adult member of the metropolitan urban American Indian community in Detroit who had limited prior knowledge of or experience with Indigenous traditional spirituality. The program was a structured orientation to these Indigenous spiritual practices that would be offered by AIHFS for one three-hour session per week for 12 weeks. The purpose of the UAITSP was to inaugurate a spiritual devotional life for urban American Indian participants, with the expectation that regular program engagement would result in beneficial and measurable wellness outcomes. These outcomes, we anticipated, would result from socialization into familiarity with and participation in the sweat lodge ritual (including all of its key components). To navigate the many cultural sensitivities surrounding this action research project, we routinely communicated several foundational attributes of the program. First, the UAITSP had been formally commissioned by the AIHFS administration. Second, the UAITSP was guided in its creation by the Traditional Teachers Advisory Council and their designated ceremonial leader. Third, the UAITSP was developed "by Indians, for Indians." Fourth, the UAITSP would be implemented by regionally recognized American Indian facilitators (with knowledge of *Anishinabe* and/or *Haudenosaunee* traditions). Fifth, the UAITSP would ideally be facilitated by man and woman coleaders. Sixth, the UAITSP would be structured as a written curriculum (to allow for possible future program dissemination and evaluation). Finally, the UAITSP would entail documentation of general traditional teachings but *not* ritual details (which was considered essential for protecting these practices from misappropriation by non-American Indian outsiders).

The structure of the UAITSP curriculum entailed a session dedicated to program orientation, four sessions of traditional teachings, participation in a sweat lodge ceremony, four more sessions of traditional teachings, participation in a second sweat lodge ceremony, and a community gathering to celebrate participant graduation from the program (Gone et al., 2020). The UAITSP included 20 curricular components such as instruction about traditional prayer, sacred medicines, the smudging rite, gender roles, the (masculine) pipe ceremony, the (feminine) water ceremony, drumming and singing, fasting and visions, feasting and traditional foods, tobacco ties, giveaways, talking circles, approaching an elder, and language and ceremony. Three recurrent admonitions included tolerance for cultural diversity (as urban American Indian communities are multitribal), the ceremonial importance of maintaining positive attitudes and open hearts, and observance of ritual restrictions surrounding women's menstrual cycles (which are understood to potently disrupt some forms of ceremonial activity). Anticipated wellness outcomes that were hypothesized to result from participation in the UAITSP included enhanced cultural identity, increased spirituality, intensified cultural involvement, expanded community mindedness, reduced distress/symptoms, improved emotional regulation, strengthened coping skills, augmented social support, buttressed help-seeking attitudes, and greater life satisfaction. Perhaps the most important feature of this action research endeavor was the signature innovation to "teach tradition" through a fully structured didactic curriculum that would be portable to other urban American Indian communities and replicable for purposes of obtaining larger sample sizes in the context of formal outcome evaluation.

The UAITSP was implemented as a pilot program at AIHFS in the Winter and Spring of 2016 (Gone et al., 2017, 2020). AIHFS staff member Nickole Fox coordinated various administrative facets of the pilot implementation, recruiting 10 Detroit-area American Indian participants for the inaugural offering. The program was expertly facilitated by Joe and Joan Jacobs, who skillfully managed the demanding task of adhering to the written curriculum even while flexibly responding to participant interest and engagement in an interpersonally warm and accessible manner. The sweat lodge ceremonies were conducted by regional cultural leader Anthony Davis. My research team dispatched an observer for all sessions so that we could monitor any curricular challenges that arose throughout the pilot implementation and attempt to address these between sessions. For example, it became clear early on that the Jacobses were having trouble following the facilitator instructions in the printed curriculum, and so the research team created PowerPoint slides for each week's detailed curriculum outline that resolved this problem. Once the pilot program had concluded, my research team interviewed nine of the 10 participants for purposes of assessing program experiences and soliciting suggestions for improvement. Thematic analysis of these interview responses yielded two major themes (Pham et al., in press). First, *positive impact on personal well-being* included improved psychological and spiritual well-being, enhanced connection to the community, increased cultural knowledge, and a desire for further learning and sharing. Second, the *desire for an ongoing program* included recommendations to shift to drop-in "classes" (to better accommodate busy schedules), to incorporate additional domains of sacred knowledge and practice, to include more knowledge holders and their perspectives, and to develop a sequence

of staged program tiers for various participant levels of familiarity and expertise.

Beyond this pilot implementation of the UAITSP, future directions for this innovative health program will likely include further refinement of the curriculum, soliciting resources for additional offerings of the program, and proposed circulation to other urban American Indian health clinics in a manner that might afford portable replication and robust outcome evaluation. Replication and evaluation will be especially important for helping to legitimate culture-as-treatment with respect to professional accountability and evidence-based practice. In sum, this most recent action research project to teach tradition to the urban American Indian community in Detroit (Gone et al., 2017, 2020) is the culmination of lessons drawn from nearly three decades of collaborative inquiry with American Indian communities addressed to alternative mental health services. Many American Indian communities desire health programs that integrate, include, or depend on Indigenous therapeutic traditions. Moreover, programs designed in this manner will frequently include Indigenous spiritual and religious practices, which are often recognized locally as potent sources of robust health and well-being. Thus, in good community psychology fashion, researcher commitments to diversity, collaboration, and empowerment can ensure design of relevant and responsive health interventions for these constituencies. Such action research must proceed in a participatory manner because American Indian community members remain the experts on their own Indigenous therapeutic practices, which requires that community-based program development be initiated, guided, and implemented by local partners. In addition, American Indian sensitivities surrounding adoption and promotion of such traditions must be honored in these efforts, which necessitates the adoption of anticolonial research approaches to help remedy the long legacy of colonial subjugation and exploitation in these communities (Gone, 2021a, in press-a).

CLOSING

Although American Indian communities suffer from mental health inequities such as addiction, trauma, and suicide, conventional mental health services such as counseling and psychotherapy emerge from and depend on assumptions and aspirations that may not fit well with Indigenous cultural sensibilities. Given the brutal history of Euro-American colonization, such differences have the potential to further alienate American Indian community members from the very services and providers designated to help them. In this article, I have reviewed a program of research that has sought to harness American Indian cultural and spiritual traditions for unprecedented innovations in psychosocial helping services for these populations. First, I observed that community mental health services for American Indians are vexed by a postcolonial predicament. Then, I explained that professional and Indigenous therapeutic traditions can diverge in substantial cultural ways. Next, I noted that there is broad American Indian interest in reformulating helping services toward greater cultural commensurability. In addition, I acknowledged that a compelling point of departure is the American Indian claim that "our culture is our treatment." Furthermore, I demonstrated that culture-as-treatment projects may depart substantially from recognizable forms of psychosocial treatment. Finally, I concluded that scientific evaluation of culture-as-treatment projects remains a worthy but fraught endeavor. Ultimately, it is the enduring legacy of community psychologists such as Seymour Sarason that has made possible this disciplinary endeavor in which I have sought to reimagine mental health services in a manner that truly centers Indigenous perspectives.

CONFLICT OF INTERESTS

The author declares that there is no conflict of interests.

ORCID

Joseph P. Gone http://orcid.org/0000-0002-0572-1179

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