

PRACTICE MAKES PERFECT? IDENTIFYING EFFECTIVE PSYCHOLOGICAL TREATMENTS FOR MENTAL HEALTH PROBLEMS IN INDIAN COUNTRY

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Identifying Effective Psychological Treatments for Mental Health Problems in Indian Country

That's kind of like taboo. You know, we don't do that. We never did do that. If you look at the big picture—you look at your past, your history, where you come from—and you look at your future where the Whiteman's leading you, I guess you could make a choice: Where do I want to end up? And I guess a lot of people want to end up looking good to the Whiteman. Then it'd be a good thing to do: Go [to the] white psychiatrists in the Indian Health Service and say, "Rid me of my history, my past, and brainwash me forever so I can be like a Whiteman." I guess that'd be a choice each individual will have to make.

—Winston (cited in Gone, 2004c)

As many U.S. citizens well know, this nation's tiny but diverse population of American Indians and Alaska Natives has endured centuries of colonial peril. Indeed, historical encounters of Native peoples with Euro-Americans in the United States all too frequently involved military conquest, reservation captivity, assimilation campaigns, resource theft, and numerous other dangers, both mortal and ideological (Jaimes, 1992). These experiences—some of which persist to this day—have collectively established and transformed the psychologies of contemporary tribal peoples, in many instances complicating, compromising, and confounding "mental health" in these communities. For good reason then, many contemporary tribal peoples remain suspicious of the ultimate relevance and utility of conventional psychological interventions proffered by Euro-American mental health professionals (as revealed in the opening quotation of an elder on the first author's home reservation).

Although methodologically sophisticated research on the current incidence and prevalence of psychiatric distress or mental disorder in "Indian country" is difficult to come by (Gone, 2003; Manson & Altschul, 2004; U.S. Department of Health & Human Services, 2001),

recent scientific surveillance attests to high levels of “frequent mental distress” reported by Native American respondents (Zahran, et al., 2004). In addition, recent community-based epidemiological findings attest to the elevated lifetime prevalence of Alcohol Dependence (Spicer, et al., 2003), Drug Dependence (Mitchell, Beals, Novins, Spicer, & the AI-SUPERPPF Team, 2003), and Posttraumatic Stress Disorder (Buchwald, Goldberg, Noonan, Beals, Manson, & the AI-SUPERPPF Team, 2005) within reservation populations. Anecdotal evidence further attests to alarming rates of other kinds of psychological dysfunction within these communities, including mood disorders, pathological reactions to violence and trauma, and suicide (Indian Health Service, 2005; U.S. Congress, Office of Technology Assessment, 1990).

Inasmuch as it remains an ethical obligation of the U.S. federal government in fulfillment of its Trust Responsibility to provide health care services to citizens of federally recognized tribal nations (Pevar, 2004), the identification of state-of-the-art psychological treatments for mental health problems in Indian country would seem crucial to ensuring that American Indians and Alaska Natives obtain reliably accessible and demonstrably effective therapeutic interventions in times of distress. Unfortunately, the identification of “best practices” in the treatment of mental health problems for Native Americans is no simple endeavor. This chapter will canvass the scientific literature related to this effort, while simultaneously reviewing concepts and approaches that frame (and complicate) the worthy pursuit of evidence-based practice in American Indian mental health service delivery.

Previewing “Best Practices”: Assumptions and Approaches

Clinical psychologists, psychiatrists, social workers and other allied mental health professionals are increasingly interested in incorporating “evidence-based practice” (or EBP) into their treatment of distressed clients (see McFall, 2000, for an exemplar from clinical

psychology). Originating within professional medicine in the United Kingdom, EBP aspires to anchor clinical applications to the existing body of scientific evidence concerning therapeutic outcomes (Wampold & Bhati, 2004). For example, the American Psychological Association's Division 12 (Society for Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures released a report in 1995 identifying "empirically validated" (or, in more contemporary parlance, "empirically supported") treatments for a variety of psychological disorders based upon explicit evaluation criteria pertaining to the quality of the empirical outcome literature associated with a given intervention (Chambless, et al., 1996). Treatments are considered "well established" if their therapeutic efficacy has been demonstrated to be superior to a placebo (or to be equivalent to an already supported treatment) in two or more randomized, controlled experiments undertaken by two or more research teams. Treatments are considered "probably efficacious" if their therapeutic efficacy has been demonstrated to be superior to a "waitlist" control group (instead of a placebo), or if only one experiment (instead of two or more) attested to its efficacy. The most recently published list of such treatments includes 108 well-established or probably efficacious treatments for adult psychological disorders and 37 for childhood disorders, including, for example, Exposure and Response Prevention for Obsessive Compulsive Disorder, or Interpersonal Therapy for Major Depressive Disorder (Chambless & Ollendick, 2001).

Not surprisingly, officially sanctioned lists that are developed and disseminated by professional organizations have engendered fierce controversy because many mental health professionals have been accustomed to providing therapeutic services to their clients based not upon scientific evidence in support of their particular tools or techniques, but instead upon professional conventions that result from training, experience, intuition, and/or preference. Nevertheless, proponents of EBP offer a compelling rationale for considering scientific evidence

as superior to these conventions. Note at the outset, however, that this rationale applies to professional interactions involving what we designate as the “therapeutic triad,” in which *credentialed clinicians* provide *costly services* to *vulnerable clients* suffering from clinically significant psychological impairment or distress.

The therapeutic triad recognizes that clinicians are credentialed (usually through Master’s or doctoral level training in accredited programs, plus professional licensure in the state in which they practice) precisely because they provide professional services that presumably require expertise beyond the facility of the general public to evaluate independently—in such instances, the philosophy of “caveat emptor” is trumped by the quality control efforts of relevant civic and professional bodies. Furthermore, these expert professional services are understood to be relatively scarce and, therefore, costly—indeed, the majority of individuals experiencing diagnosable psychological distress in their lifetimes do not obtain specialized mental health treatment for their problems (Kessler, et al., 1994), owing in part to the limited availability and high cost of these services (U.S. Department of Health & Human Services, 1999). Finally, persons who obtain such services are typically contending with rather serious psychological disruptions in their lives and livelihoods—if ever individuals are in need of quality control and assurance to inspire their trust, bolster their confidence, and protect their interests, it is in these particularly vulnerable moments when sometimes even life and liberty are at stake. Thus, in instances properly characterized by the therapeutic triad, the professional obligation to provide the most effective therapeutic services available would seem beyond controversy or dispute.

Nevertheless, controversy or dispute arises because clinicians engaged in the active treatment of clients or patients (a) believe and often proclaim that their services are in fact the “most effective” among the available alternatives (otherwise, they would not recommend them),

and (b) disagree not infrequently with their colleagues about the treatment of choice for various psychological conditions or disorders (again, often based upon their professional training, experience, intuition, and/or preference). Obviously, under such circumstances, some professionals—at least some of the time—are advancing erroneous claims on behalf of their “pet” therapies, approaches, or interventions (for provocative reviews, see Dawes, 1994a; Garb, 1998; Lilienfeld, Lynn, & Lohr, 2003). The EBP movement within the mental health professions contends that identification of the most effective therapeutic services among the available alternatives is a scientific question that should be answered through consideration of the results of carefully controlled experiments assessing the causal efficacy of proposed or supposed mental health treatments. That is, proponents of EBP routinely address such questions through recourse to a *scientific epistemology*. While it is difficult to generalize from paleontology to particle physics, or from astronomy to sociology, a scientific epistemology typically renders knowledge claims using methods that involve the precise, observer-independent measurement of phenomena that are cumulatively or progressively employed to evaluate falsifiable characterizations of the phenomena. By “observer-independent” we simply mean that any competent specialist should be able to reproduce the observations, and therefore that such observations are not dependent upon which specialist observes them. Moreover, in terms of establishing reliable causal attributions, the method of choice employed by scientists is the experiment, and in terms of establishing therapeutic outcomes in particular, the preferred form of experiment is known as a randomized clinical trial.

Readers who are less familiar with scientific approaches to mental health intervention may wonder what all the fuss is about: if we treat Jane Deer Woman, who suffers from Hang-Around-the-Fort Disorder, with our novel Back-to-the-Blanket Therapy, and Jane improves substantially during the course of treatment, is it not obvious that our therapeutic efforts were

effective in curing Jane of her disorder? Owing to a formidable cadre of cognitive tendencies that routinely besiege human inference (Dawes, 1994b, 2001), the psychologist's answer is, regrettably, no. Reliable attribution of cause and effect relationships, especially in the convoluted context of human behavior and interaction, is extremely difficult (if not altogether impossible) for us to render casually or "off the tops of our heads."

For example, Jane's improvement during the course of therapy might have occurred due to (a) other significant life changes that were coincident with but independent of her treatment (e.g., obtaining a seat on the tribal council, winning a high stakes bingo tournament, or finding a new "honey"), or (b) personal expectation that things could only improve now that she was finally working to solve her longstanding problems (i.e., the so-called placebo effect), or (c) obtaining treatment (as so many people do) during the most overwhelming moments of her chronically troubled life, virtually ensuring that improvement over time was inevitable, again independent of treatment (i.e., "regression toward the mean"). Worse yet, perhaps Jane only supposed herself to have improved (despite contradictory evidence in her daily life that neither she nor her therapist fully recognize) because she wanted desperately to believe that she was recovering or she wanted subconsciously to reassure her therapist that his expertise was indeed profound. In fact, the only way to be certain whether our innovative therapy cured Jane of her disorder would be for an omniscient observer to travel back through time and withhold the treatment (and only the treatment, ensuring not to alter anything else in the past) in order to determine whether Jane this time around did not actually recover from her disorder. Absent this sort of fantastic impossibility, there is generally no definitive way¹ to know whether a given intervention causes a specific patient to improve or her symptoms to remit—there are just too many competing plausible explanations for the patient's recovery to afford clear and authoritative conclusions about the causal efficacy of the intervention in any particular instance.

Rather than rely upon overdetermined interpretations of case histories to draw conclusions about cause and effect, clinical scientists seek instead to provide probabilistic accounts of whether treatments are “likely” to benefit individuals in distress by testing interventions on groups of patients and comparing post-treatment results between the group that received the novel intervention (the treatment condition) and the group that did not (the comparison or control condition). Throughout the history of medicine, professional debates about the causal efficacy of certain treatments—usually fueled by passionate arguments grounded in professional training, orientation, experience, intuition, and/or personal preference—sometimes endured for centuries (e.g., whether therapeutic advantages obtained in wound debridement [reviewed briefly by Meehl, 1997]) before eventual resolution through this kind of scientific experimentation. For nearly two decades, for example, the use of streptokinase to treat myocardial infarction was professionally contested despite the fact that experimental evidence attesting to its efficacy was merely awaiting proper analysis to resolve the dispute definitively (Hunt, 1997, as cited in Wampold & Bhati, 2004)—had these data been properly appraised early on, countless lives might have been saved. In short, owing to the demonstrated constraints of unassisted and undisciplined human cognition, the scientific experiment would seem to be the methodology of choice for reliably ascertaining causal relationships in the complex circumstances represented by therapeutic intervention in the health professions.

In the social and health sciences, the experiment is characterized by the *random assignment* of research participants to either the designated treatment condition or the comparison condition (which does not receive the treatment in question but instead obtains either a different treatment or awaits treatment at the conclusion of the experiment). Random assignment is the key to interpreting experimental outcomes because it alone ensures the

“probabilistic equivalence” of the two groups of participants, such that the only *systematic* differences between the participants that might account for post-experiment divergences in group outcome —assuming the experimental design remains intact throughout the investigation—is the treatment itself (see Campbell & Stanley, 1963, for a classic discussion, and Kendell, Butcher, & Holmbeck, 1999, for a contemporary overview). Desirable indicators of treatment response, improvement, or recovery are specified in advance and measured as accurately as possible for all participants both before and after the experiment. Between-group differences on these outcome measures are usually analyzed statistically to determine whether positive treatment effects were in fact demonstrated according to prescribed research conventions (e.g., the assumptions undergirding particular kinds of statistical inference).

It should also seem obvious by now that in order to isolate the causal relationships involved in such experimental research, the conditions in randomized clinical trials are often quite “artificial” compared to “real world” service delivery—for example, participants might be selected because they suffer only from the disorder of interest (while most patients suffer from additional “comorbid” disorders as well), or clinicians might be monitored for their adherence to the treatments being tested (while the practices of most licensed clinicians are not scrutinized at all), or psychological changes associated with treatment are rigorously assessed with objective tests and measures (while many therapists do not employ standardized outcome measures of any kind). Even though these decisions help to ensure that research results are interpretable by clinical scientists relative to the causal relationships of interest, it is important to note that they also rearticulate the therapeutic encounter in ways that may or may not easily generalize to workaday professional practice.

In sum, having embraced the epistemological advantages of randomized clinical trials, the EBP movement aspires to relocate professional practice from the quicksand of clinical

intuition to the terra firma of scientific authority. Projects such as that undertaken by the Division 12 Task Force of the APA have specified evaluative criteria, reviewed the scientific literature, and published a list of empirically supported treatments for perusal and adoption by mental health professionals—similar evidence-based “effective practices,” “model programs,” and mental health “treatment guidelines” have been published by other government and professional organizations as well. Nevertheless, questions regarding the portability (or “generalizability” or “external validity”) of these interventions to workaday clinical settings have been raised (Garfield, 1996; Peterson, 1996), including their relevance for populations of color in the contemporary U.S. (Bernal & Scharron-Del-Rio, 2001; Coleman & Wampold, 2003; Nagayama Hall, 2001). The principal goal of this chapter is to review the *Native-specific* literature on evidence-based “best practices” in mental health treatment for the most prevalent psychological disorders in Indian country.

Reviewing “Best Practices”: Locating the Literature

From the outset of this endeavor, scientific literature describing Native-specific, evidence-based mental health interventions—deliberately excluding substance abuse treatments for separate coverage—promised to be an elusive quarry. For instance, in the most recent edition of the seminal *Handbook of Psychotherapy and Behavior Change*, Zane, Nagayama Hall, Sue, Young, and Nunez (2004) observed that:

Very few empirical studies have been conducted on the effectiveness of psychotherapy in the treatment of American Indians and Alaska Natives, and no research has investigated the relative effectiveness of different therapeutic modalities. The need for outcome research is apparent given the proliferation and funding of a wide variety of treatment and prevention programs that have arisen to target the serious mental health needs of many American Indians and Alaska Natives. Given these efforts, the lack of research on outcome must be considered a serious problem. (p. 779)

Other recent overviews of Native American mental health issues have also attested to the

dearth of published literature assessing therapeutic outcomes with this population (U.S. Department of Health & Human Services, 2001; Gone, 2003; Manson & Altschul, 2004).

Nevertheless, in order to ensure a systematic and comprehensive review of this literature, we undertook a series of on-line searches within four computerized bibliographic databases encompassing English-language citations of scholarly publications in the mental health field: PsycInfo, Medline, Social Work Abstracts, and the Social Sciences Citation Index. In order to accurately identify all of the Native-specific literature on “best practices,” the proxy descriptors “treatment,” “prevention,” and “intervention” were chosen since they were presumed to be inclusive of any associated terms used to catalog pertinent outcome studies. In addition, twelve descriptors of mental health problems were employed in the database searches based upon anecdotal evidence attesting to their prevalence in and relevance for Indian country. More specifically, these problem descriptors included: mental disorders, depression, suicide, Posttraumatic Stress Disorder (PTSD), emotional trauma, child abuse, sexual abuse, Attention Deficit Hyperactivity Disorder (ADHD), antisocial behavior, conduct disorder, juvenile delinquency, and post colonial stress disorder. Finally, “Native American” and “American Indian” were the terms selected as racial group identifiers designed to limit search results to the Native-specific literature—use of these identifiers varied depending upon the database in question (e.g., PsycInfo prescribed use of the latter rather than the former).

Searches employing the aforementioned descriptors within the respective databases (Computerized Database [4] x Practice Descriptor [3] x Problem Descriptor [12]) resulted in 144 searches, yielding 2,670 citations. These results were further supplemented by a manual search of the “Health and Mental Health Treatment and Prevention” section of a published bibliography of psychological abstracts pertaining to Native Americans (Trimble & Bagwell, 1995). Not surprisingly, many of these searches returned the same citations, all of which were

meticulously checked for relevance to the task of identifying EBP in Indian country. Adoption of liberal (and, admittedly, somewhat subjective) inclusion criteria resulted in a corpus of 46 articles and chapters related to Native-specific mental health programs, interventions, and treatment approaches (see Appendix), excluding substance abuse treatment. This literature was classified as follows: (a) randomized controlled outcome studies ($n = 2$); (b) non-randomized and/or uncontrolled outcome studies ($n = 4$); (c) intervention descriptions ($n = 14$); (d) intervention overviews ($n = 2$); (e) clinical case studies ($n = 4$); and (f) intervention approaches ($n = 20$). By way of brief summary, this literature described prevention of maladaptive adolescent behaviors and suicide through the cultivation of coping skills and pro-social competencies; treatment of depression, trauma, and sexual abuse through both conventional and innovative therapeutic methods; application of extended family therapy, relaxation and assertiveness training, Eye Movement Desensitization and Reprocessing therapy, and stimulus fading procedures in single clinical cases; and implementation of innovative service delivery efforts within mental health treatment systems and settings in Indian country.

Of particular relevance to the identification of EBP, of course, are the six outcome studies—the remainder of the citations may be interesting and useful from the perspective of documenting programs or treatments that have been offered to Native American clients, enhancing therapeutic techniques presumably toward greater effectiveness in Indian country, or designing novel and alternative helping interventions for mental health problems experienced by Native people, but none of these speaks to the question of scientifically-demonstrated therapeutic outcomes raised by the EBP movement. It is nevertheless interesting to note that the vast majority of these citations are not explicitly concerned with the assessment of therapeutic outcomes, and nearly half of them are observation or reflection pieces comprised of

suggestions and recommendations for improving therapeutic services for Native Americans (with particular emphasis upon the cultural transactions implicated in mental health service delivery and the alternative community-based programs and organizational ecologies that might better suit Native American worldviews and cultural practices). In short, very few of these articles and chapters are *empirical reports*, and thus their value for identifying Native-specific, *evidence-based* mental health treatments is virtually nil.

Of the six outcome studies classified above, three (Centers for Disease Control and Prevention, 1998; Husted, Johnson, & Redwing, 1995; Kahn, Lewis, & Galvez, 1974) reported pre- and post-intervention results for a treatment group with no untreated group for comparison, thereby rendering valid inferences about the causal relationship of intervention to outcome in these instances nearly impossible (but see May, this monograph, for an elaboration upon the suicide prevention effort described by the Centers for Disease Control and Prevention, 1998). In addition, one study reported outcomes related to the efficacy of a pharmacotherapy (methylphenidate) instead of a psychotherapy for comorbid ADHD and Fetal Alcohol Syndrome among four Native children (Oesterheld, et al., 1998). Thus, the entire search for Native-specific, evidence-based mental health interventions yielded only two outcome studies with relevant, interpretable results. Manson and Brenneman (1995) reported outcomes for an intervention undertaken to prevent clinical depression among older American Indians encountering health-related stressors in the Pacific Northwest. LaFromboise and Howard-Pitney (1995) reported outcomes for an intervention undertaken to prevent suicide among adolescent American Indians through life skills training in a school-based program in the American Southwest. Each of these preventive interventions is described in further detail below.

Manson and Brenneman (1995) adapted the mainstream, well established, and

empirically supported Coping With Depression Course (Lewinsohn, Hoberman, & Clarke, 1989) for use with older Native American adults at risk for depressive symptomatology as a result of deteriorating health. Comprised of sixteen two-hour weekly sessions, the adapted curriculum emphasized skills training toward progress in four areas: rehearsed relaxation, increased pleasurable activity, improved patterns of thinking, and cultivated social skills. In order to decrease the potential stigma of an intervention related to “mental health,” the Course was offered through a local tribal college for adult education credit—participants received tuition remission in the amount of \$10 per each session attended. Curricular resources included lectures, class activities, homework assignments, a textbook, and local community members who were trained as instructors—curricular materials were modified slightly for increased cultural relevance for this sample. Twenty-two participants (aged 45+, 19 females) from four Pacific Northwest reservations who reported moderate depressive symptoms and diagnoses of diabetes, arthritis, or coronary heart disease were randomly assigned to the treatment condition, while 26 participants comprised the wait-list control group—because the sampling strategy involved recruitment of only a subset of participants randomly assigned to the intervention condition, the design was quasi-experimental in nature. Participants were assessed with a health-screening interview consisting of a host of relevant indicators (e.g., subjective health status, life satisfaction, depressive symptoms, etc.) pre- and post-treatment. Outcomes demonstrated that the Course participants experienced decreased depressive symptoms, decreased involvement in unpleasant events, and increased involvement in pleasant events (but did not report greater life satisfaction) in comparison to the wait-list control group, which evidenced statistically significant trends in the opposite direction for each of these indicators. Thus, despite the quasi-experimental nature of their research design and a relatively small sample size, Manson and Brenneman present reasonably compelling evidence in support of the

efficacy of their adapted Coping With Depression Course for preventing depressive symptoms among older Native Americans confronted with chronic health problems.

LaFromboise and Howard-Pitney (1995) developed the Zuni Life Skills Development Curriculum for use with high school students at risk for suicide in the Zuni Pueblo in New Mexico. Comprised of close to one hundred sessions offered three times weekly over the course of an academic year, the curriculum emphasized skills training toward progress in seven areas: identifying emotions, building self-esteem, increasing communication and problem-solving, eliminating self-destructive behavior, receiving suicide information, obtaining suicide intervention training, and setting goals. The curriculum—grounded in mainstream life skills training designed to prevent high-risk adolescent behaviors—was developed in close collaboration with community members to target risk factors for suicide and to ensure cultural relevance. Sixty-nine students in four classes were assigned to the treatment condition, while 59 students in four classes were assigned to the no-treatment control group—since neither students nor classes could be randomly assigned to these conditions (owing to institutional constraints), the design was quasi-experimental in nature. Participants were assessed with a self-report survey consisting of a host of relevant indicators (e.g., suicide probability, feelings of hopelessness, depressive symptoms, etc.) pre- and post-treatment. Outcomes demonstrated that the Life Skills participants were less suicidal, less hopeless, and more skillful at suicide intervention and problem solving (but *not* less depressed or more self-efficacious) in comparison to the control group, though the attrition of roughly one-quarter of the original sample by the time of administration of the post-treatment assessment complicates the interpretation of these results. Nevertheless, LaFromboise and Howard-Pitney have achieved a remarkable degree of success in pioneering a collaborative and culturally grounded preventive intervention for over 100 Native adolescents in a reservation school system—their curriculum is publicly available

(LaFromboise, 1996) and their intervention has been designated a “model program” (attesting to its status as an EBP) by the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services.

Two quasi-experimental prevention outcome studies notwithstanding, the results of our systematic bibliographic database searches attest to the rampant tendency of mental health professionals and researchers to critique conventional treatment modalities in order to recommend what are envisioned as more culturally relevant or sensitive—and therefore, presumably, more effective—service delivery options for Native American communities. In the absence of compelling empirical evidence indicating which treatments impart the most significant benefits to distressed Native people, however, the EBP movement insists upon caution and restraint in terms of professional endorsement of untested approaches and practices—no matter how promising or innovative—until rigorous evaluations are undertaken and reported in the literature. What then is the mental health practitioner to do when the press for adoption of EBP is frustrated by a scant empirical record; when, as Zane, Nagayama Hall, Sue, Young, and Nunez (2004) concluded, “it would be premature to try and address the question of the efficacy of mental health interventions” (p. 780) with this population because scientific research has yet to provide clear answers or precise guidelines regarding treatment outcomes for Native Americans with mental health problems?

Revisiting “Best Practices”: Reflections and Reconsiderations

During the planning meeting devoted to preparation of this monograph, a gathering of practitioners, researchers, and policy-makers with years of collective expertise in the arena of Indian mental health and substance abuse treatment discussed and debated the state of the professional knowledge base relative to EBP. One (usually implicit) point of contention was the

epistemological status of evidence offered in support of claims about the efficacy of Native-specific interventions. Although nearly everyone agreed that mainstream, conventional mental health and substance abuse treatments required adaptation of one kind or another prior to implementation with Native clients or patients, consensus regarding the value and utility of scientific outcome assessments was more elusive. In the course of impressive presentations typically decrying the absence of empirical outcome evidence for Native-specific programs and therapies, some members of the workgroup asserted with escalating impatience, “We *already know* what works in these communities, it’s just a question of getting the federal funding agencies to recognize this expertise.” Clearly, these individuals believed that professional training, theoretical orientation, accumulated experience, clinical intuition, and personal preference are sufficient for inferring causal relationships between clinical intervention and therapeutic outcome. As a result, they considered the EBP movement—with its increasing control of mental health resources at all levels of health care service delivery—just one more example of Euro-American arrogance and intrusion into the affairs of sovereign tribal Nations. In contrast, other participants in the gathering believed that the EBP movement facilitates greater accountability for claims of therapeutic efficacy and thereby provides a fundamental protection of vulnerable Native American clients in the context of the therapeutic triad.

The implications of these contrasting epistemological positions are indeed profound. If, on the one hand, professionals and researchers “already know” what works in Native communities, then the challenge before us is merely to persuade and/or compel those who control mental health resources either to abandon the EBP standards they have embraced or to afford exceptions to those standards for service delivery in Native American contexts—such an endeavor is *not* principally scientific but *political* in nature. On the other hand, if we remain fundamentally skeptical of our cognitive capacity to infer therapeutic cause and effect in the

absence of compelling scientific controls, then the challenge before us is instead to determine how to most effectively conduct such inquiry and report such evidence so as to develop a corpus of Native-specific EBP in mental health and substance abuse treatment—for a variety of reasons, this endeavor is *both* scientific and political in nature, with the ultimate arbiter of decisions and recommendations being the quality and credibility of the science in question. As the authors of this chapter, we suspect that our own skepticism regarding the human cognitive capacity to render complex causal inferences is by now apparent and explains why we remain sympathetic to the EBP movement. We therefore recognize the pressing urgency to develop a robust empirical literature pertaining to intervention outcomes in the arena of Native American mental health. Nevertheless, we also believe there to be substantive reasons for reconsidering the call to EBP in Native American mental health.

We have already noted concerns among mental health professionals and researchers regarding the external validity or generalizability of the outcomes of randomized clinical trials (RCTs) relative to actual clinical practice. These concerns seem intuitively legitimate in many instances, including those involving the transfer of treatments evaluated with middle-class Euro-American samples to working class or poor populations of color in the U.S. (though, as Manson and Brenneman [1995] have demonstrated, these concerns are not always substantiated—the cross-cultural portability of a given treatment is always an empirical question). At a minimum, then, the demonstration of positive therapeutic outcomes for an intervention through RCTs (i.e., the establishment of therapeutic “efficacy”) is only the *first phase* in identifying EBP; a second, crucial empirical endeavor is the establishment of parameters regarding the range of conditions and contexts in which the established causal relationship between intervention and outcome remains intact (i.e., the establishment of therapeutic “effectiveness” [see Lambert & Ogles, 2004]). Within the mental health EBP movement thus far this second phase has rarely been

undertaken, particularly in regard to the portability of designated ESTs to U.S. ethnic minority clinical contexts.

A second, more substantive set of critiques and concerns addressed to the mental health EBP movement asserts that the designation of the RCT as the gold standard for the evaluation of pharmacological interventions in medicine cannot be meaningfully extended to the evaluation of psychotherapeutic interventions in the mental health professions (Peterson, 1996, 2004; Wampold & Bhati, 2004). The nuances of this debate are well beyond the scope of this chapter, but critics of the EST movement in professional psychology argue that the provision of psychotherapy to distressed clients differs substantially from the so-called “medical model” of physicians harnessing medical technologies for the treatment of their patients’ diseases in several ways. For one, there really is no psychotherapeutic equivalent to the placebo of pharmacotherapy research since the psychological aspects of the client’s experience, the presumed engine of the placebo effect, are precisely the targets of intervention in most circumstances—indeed, the “active ingredients” of a psychotherapeutic intervention have been difficult to isolate empirically. For another, the difficulties that motivate individuals to seek psychotherapeutic treatment may not best be conceptualized as diseases in the standard medical sense—indeed, effective intervention in mental health contexts may involve a great deal more than merely ameliorating “symptoms” of postulated psychiatric “illnesses.” Finally, critics have amassed a sizable body of empirical evidence to support their contention that specific treatment procedures or techniques employed by mental health professionals do not account for therapeutic change as much as the kind and quality of the *therapeutic relationship* (and other factors common to all psychotherapies) between clinicians and their clients (Norcross, 2002; Wampold, 2004). Rather than ESTs, these critics argue, mental health professionals should pursue EBP by prescribing ESTRs (empirically supported therapeutic

relationships) instead of particular clinical techniques. In sum, according to these critics, the complexities of cause and effect in the context of psychotherapeutic intervention remain irreducible to overly simplistic technique-to-disorder outcomes (see Lambert, 2004, for an exhaustive review of these and related issues).

Finally, an even more radical perspective on Native-specific mental health intervention in particular would emphasize the current “postcolonial”² political context of American Indian mental health service delivery (Duran & Duran, 1995; Gone, 2003, 2004a, 2004b, 2004c, in press). That is, the state of the art in regard to mental health intervention in the 21st-century United States raises a series of political and ethical predicaments for Indian country, including the problem of cultural divergence in the context of persisting power asymmetries. More specifically, the culture of the mental health clinic is *not* the culture of the reservation or urban Indian community. And despite the burgeoning professional call to an increased “multicultural competency” in the delivery of psychotherapeutic services, few mental health professionals have fully interrogated the “Western” cultural ideologies that articulate and configure contemporary clinical conventions, or the assimilative transformations in non-Western subjectivities these might effect. Such powerful ideological contrasts ensure that many contemporary reservation residents remain suspicious of conventional clinical services and decline to consult mental health professionals who perhaps unwittingly propose to “brainwash” them so they can become like White men.

In contrast, in many Native communities, the contemporary status of American Indian “mental health” remains significantly caught up in history, culture, identity, and (especially) spirituality, all within the devastating context of Euro-American colonialism. For example, Winston—the elder whose words introduced this chapter (Gone, 2004c)—explained that drinking, depression, and other mental health problems on the Fort Belknap reservation are

directly resultant from the loss of sacred custom and teaching due to the Euro-American “genocide” and forced “civilization” of Indian people. In such circumstances, the “medical model” for redressing the psychological problems of Native Americans seems almost irrelevant, given that epidemic rates of distress and dysfunction that afflict too many reservation communities clearly originated in the historical moment of U.S. colonial conquest and domination. A clear question thus arises: are the solutions to these seemingly existential exigencies properly formulated in terms of health care interventions? Certainly, Winston identified the solution not as more or better mental health services (which he skeptically dismissed as a modern form of neo-colonial “brainwashing”), but the return to sacred tradition and practice (from which a renewed sense of purpose, source of coherence, and semblance of continuity might be fashioned).

Within this radical reframing of contemporary Native American mental health problems, the role of EBP within the framework of the therapeutic triad is only of marginal relevance. Instead, mental health professionals dedicated to assisting American Indian communities might seek to embrace new kinds of roles and relationships to the citizens they seek to serve. Rappaport and Seidman (1983), who advocate a community psychology perspective (see also Rappaport & Seidman, 2000), have outlined several distinctions between traditional clinical services and community mental health and traced the implications of these distinctions along a continuum of mental health service delivery. For example, instead of extended psychotherapy, the strategy of service in community mental health is aimed at reaching large numbers of people through brief consultations and crisis intervention; instead of the clinician’s office, the location of intervention is practice in the community; instead of assuming an intrapsychic cause of disorder, the etiological factors of interest are the environmental causes of maladaptation; instead of rehabilitative services or “treatments,” the type of service delivery is often preventative in nature;

instead of professional control of mental health services, the locus of decision making is shared responsibility between professionals and community members; etc. Although the profound implications of an approach grounded in community psychology for Native American mental health service delivery are beyond the scope of this chapter (see Gone, 2003, for an extended discussion), they certainly suggest important alternatives in terms of professional roles and relationships that might render the current discourse of EBP much less salient even as they facilitate greater progress toward effectively redressing the postcolonial ills of contemporary Native American societies. As always, however, such progress will need to be charted through the rigorous scientific assessment of purported outcomes.

Conclusion

As the first author of this chapter has noted elsewhere, American Indian and Alaska Native communities require “a great deal more of the kinds of professional mental health services that do not yet exist” (Gone, 2003, p. 228). As our review has hopefully made clear, the EBP movement within the mental health professions has contributed much to clinical practice, providing therapists with scientific outcome evidence to substantiate their claims of efficacy for many state-of-the-art mental health interventions. A systematic survey of the scientific literature, however, indicates that treatment outcomes have not been empirically assessed or reported for Native American persons suffering many prevalent forms of debilitating psychological distress. What then are mental health professionals who are dedicated to service delivery with American Indian people to do? We have briefly discussed a variety of possibilities, ranging from additional investment in efficacy and effectiveness studies of Native-specific clinical interventions to the professional adoption of alternative roles and relationships well outside of the framework provided by the therapeutic triad. In the end, these alternatives are

together united by the scientific call for supporting professional claims through the empirical demonstration of positive therapeutic outcomes. To the extent that this epistemological commitment drives the EBP movement, its advocates and proponents have something important to contribute toward personal and communal healing and restoration in twenty-first-century Native America.

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Notes

¹ One exception to this generality is the single-case experimental design in which a treatment is successively administered to and withheld from a single individual over numerous trials and patterns of symptom appearance and attenuation are closely monitored. In such instances, inferences of causal efficacy may be justified. Of course, the range of difficulties for which this research strategy might be ethically and practically employed is exceedingly narrow.

² In considering the colonial experience of the indigenous peoples of the United States, the issue of appropriate terminology becomes tantamount. Despite its currency in contemporary literary circles, the term “postcolonial” seems inappropriate to the contemporary indigenous circumstance because the colonizers (or their descendants) retain dominance over the domestic, political, and economic affairs of tribal communities—indeed, the U.S. Congress might well exercise its plenary power to terminate tribal communities at any time. At the same time, the term “colonial” also seems inappropriate because U.S. policies of military conquest, occupation, and resource theft ended a few short generations ago. In fact, since the era of self-determination commenced in the 1970s wherein tribal governments exercise a degree of authority and autonomy uncharacteristic of colonial subjects in other parts of the world, the term “colonial” seems even less appropriate. Furthermore, for several generations now many American Indian peoples have found innovative sources of meaning and coherence within established Euro-American symbols and institutions (e.g., sovereignty, literacy, legal claims, military service, blood quantum, IRA governance, Christianity, star quilting, cattle ranching, casino operation, tribal college administration, etc.), effectively rendering them distinctively our own (in the postcolonial sense). In order to capture this extremely complex state of affairs, we have chosen to adopt the ambiguous term “(post)colonial” from Chadwick Allen (2002), albeit with slightly different connotations.

Appendix: Native-Specific Mental Health Prevention/Intervention Outcome Citations (N = 46)

Randomized Controlled Outcome Studies (n = 2):

Manson, S. M. & Brenneman, D. L. (1995). Chronic disease among older American Indians: Preventing depressive symptoms and related problems of coping. In D. K. Padgett (Ed.), *Handbook on ethnicity, aging, and mental health* (pp. 284-303). Westport, CT: Greenwood.

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Non-Randomized and/or Uncontrolled Outcome Studies (n = 4):

Husted, J., Johnson, T., & Redwing, L. (1995). Multi-dimensional adolescent treatment with American Indians. *American Indian and Alaska Native Mental Health Research*, 6(3), 23-30.

LaFromboise, T. D. & Howard-Pitney, B. (1995). The Zuni life skills development curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology*, 42(4), 479-486.

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Intervention Descriptions (n = 14):

Problem-focused (n = 10)

Devlin, R. E. (2001). Suicide prevention training for Aboriginal young adults with learning disabilities from Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE). *International Journal of Circumpolar Health*, 60(4), 564-579.

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Institution-focused (n = 4)

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Intervention Overviews (n = 2):

Middlebrook, D. L., LeMaster, P. L., beals, J., Novins, D. K., & Manson, S. M. (2001). Suicide prevention in American Indian and Alaska Native communities: A critical review of programs. *Suicide and Life-Threatening Behavior*, 31(Supp.), 132-149.

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Clinical Case Studies (n = 4):

Thomas, R., & Gafner, G. (1993). PTSD in an elderly male: Treatment with Eye Movement Desensitization and Reprocessing (EMDR). *Clinical Gerontologist, 14*(2), 57-59.

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* Actual published article or chapter was not available for this review; instead, the citation's abstract provided information used for classification.

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AMERICAN INDIANS AND ALASKA NATIVES**

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