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A Community-Based Treatment for Native American Historical Trauma: Prospects for Evidence-Based Practice

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Nineteen staff and clients in a Native American healing lodge were interviewed regarding the therapeutic approach used to address the legacy of Native American historical trauma. On the basis of thematic content analysis of interviews, 4 components of healing discourse emerged. First, clients were understood by their counselors to carry pain, leading to adult dysfunction, including substance abuse. Second, counselors believed that such pain must be confessed in order to purge its deleterious influence. Third, the cathartic expression of such pain was said by counselors to inaugurate lifelong habits of introspection and self-improvement. Finally, this healing journey entailed a reclamation of indigenous heritage, identity, and spirituality that program staff thought would neutralize the pathogenic effects of colonization. Consideration of this healing discourse suggests that one important way for psychologists to bridge evidence-based and culturally sensitive treatment paradigms is to partner with indigenous programs in the exploration of locally determined therapeutic outcomes for existing culturally sensitive interventions that are maximally responsive to community needs and interests.

Keywords: American Indians, evidence-based practice, cultural sensitivity, community mental health services, historical trauma

During the past few decades, health services in the United States, Great Britain, and Canada have been shaped by considerations of the evidentiary warrant for undertaking clinical interventions with health care consumers (Institute of Medicine, 2001). Professional psychologists, many of whom provide health care services, have been asked to provide empirical justification for their treatment of distressed clients (Spring, 2007). According to Kazdin (2008), *evidence-based practice* (EBP) is comprised of clinical activities that are "informed by evidence about interventions, clinical expertise, and patient needs, values, and preferences," whereas *evidence-based treatment* (EBT) refers more specifically to "interventions or techniques that have produced therapeutic change in controlled trials" (p. 147). For professional psychologists, these are comprised of the "empirically supported" interventions identified by the Task Force on the Promotion and Dissemination of Psychological Procedures of the American Psychological Association, as intermittently updated (Chambless & Ollendick, 2001). These efforts express the emerging disciplinary consensus that the ethical and effective practice of psychology must be guided by the best available outcome evidence (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006).

Alongside the EBP movement within the profession, multicultural psychologists have long decried the "monocultural" bias of the field (Betancourt & López, 1993). Rogler (1999) implicated the procedural norms of the discipline as a source of cultural insensitivity, advocating instead for investigator willingness to set aside culturally biased preconceptions to discover the locally meaningful psychological attributes and actions of diverse respondents. With regard to disciplinary practice, first-hand encounters with diverse clients in an increasingly multicultural society have led some professional psychologists to champion culturally sensitive approaches to clinical intervention (Sue, 1998). The principal critique expressed in this literature is that mainstream psychological services originating out of the life experiences of Europeans and European Americans are frequently alienating, assimilative, or otherwise harmful for the "culturally different." Instead, mental health professionals should provide "culturally competent" services that are appropriately adapted to diverse client constituencies (Sue, Zane, Hall, & Berger, 2009).

In seeking to reconcile the literature concerned with EBTs on the one hand and *culturally sensitive therapies* (CSTs) on the

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other, Hall (2001) acknowledged that a chasm exists between EBT and CST researchers. He explained this divide in part by the fact that CST researchers attempt to address the divergent experiences of ethnoracial minority groups, relative to the cultural mainstream. Nevertheless, Hall acknowledged that CSTs are "unlikely to become part of mainstream psychological science without an empirical basis" (p. 508). As a result, he recommended that investigators start with established EBTs, evaluating these interventions in light of their relevance for ethnoracial minority populations. More recently, Whaley and Davis (2007) echoed Hall's analysis, promoting the evaluation of empirically established interventions with ethnoracial minority clients, even if it turns out that cultural modifications to these approaches are required. In sum, these prominent multicultural psychologists have promoted a strategy for achieving cross-cultural EBP by first selecting well-established EBTs and then evaluating these, as adapted for cross-cultural relevance, in terms of their effectiveness.

And yet, the multicultural critique of professional psychology proposes that the danger of "West-is-best" therapeutic intervention may extend well beyond the relatively superficial trappings of cultural packaging (Gone, 2008a). In light of the burgeoning consensus described above, the question becomes whether the accommodation of EBTs to culturally diverse populations through incremental modification and evaluation can adequately address the full sweep of the multicultural critique. This article explores this question through empirical elucidation of actual therapeutic discourse in a Native American community-controlled treatment program targeting historical trauma (HT). Rather than assuming in top-down, prescriptive fashion that incremental adaptations to EBTs are the ideal point of departure for determining EBP for culturally diverse populations, this study approaches the question in light of the emergent qualities of community-controlled therapeutic services in bottom-up, descriptive fashion. The point of departure adopted here is the nuanced consideration of the therapeutic orientations and objectives of Native practitioners who work with Native clients in a Native-controlled treatment setting. Ultimately, this alternative investigative strategy illuminates several additional challenges to the consolidation of EST and CST approaches that were not addressed by Hall (2001), Whaley and Davis (2007), or other proponents of multicultural EBP.

Native Americans and Historical Trauma

As the contemporary descendents of the indigenous peoples of North America, contemporary Native Americans have been shown to suffer from disproportionately high degrees of psychological distress (Zahran et al., 2004). Both researchers and professionals have consistently associated this distress with indigenous historical experiences of European colonization (E. Duran, 2006; Kirmayer, Simpson, & Cargo, 2003). Indeed, professional and community discourse regarding mental health in Native North America is distinguished by this emphasis on the impact of colonization on indigenous communities (Gone, 2007), occasioning professional and scientific interest in HT among Native people. That Native peoples are at greater risk for experiencing traumatic events in their lives would be difficult to dispute (Manson, Beals, Klein, Croy, & the AI-SUPERPFP Team, 2005). In contrast to personal experiences of a traumatic nature, however, HT calls attention to the intergenerational accumulation of risk for poor mental health status among Native peoples that purportedly originates from the depredations of past colonial subjugation, including ethnocidal policies and practices.

Brave Heart (2003), in tangent with E. Duran and Duran (1995), has introduced and promoted the concept of HT with regard to the mental health status of contemporary Native people. Although certain aspects of this concept remain vague or even contradictory, Native American HT is modeled after longstanding clinical observations of the adverse psychological effects of the Shoah not just for Holocaust survivors, but also for their offspring (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & McCarrey, 1998). In the North American context, these researchers have posited a collective, cumulative, and intergenerational transmission of risk for adverse mental health outcomes that stem from the historical unresolved grief or "soul wound" inflicted by experiences of colonization. These pathological reactions are said to diverge substantially from established categories of psychopathology, but nevertheless include many of the symptoms of complicated bereavement and complex posttraumatic stress disorder (PTSD). Despite intermittent instances of skeptical critique (Gone, 2008d; Waldram, 2004) and the more general absence of rigorous scientific investigation (but see Whitbeck, Adams, Hoyt, & Chen, 2004), Native American HT has proliferated widely as a clinically relevant concept throughout the human services during the past 15 years (Evans-Campbell, 2008; Lambert, 2008; Waldram, 2004). Thus, regardless of its future empirical status as a scientific construct, HT is already entrenched as a folk discourse in therapeutic, behavioral health, and human services circles throughout Native North America.

A proximal expression of colonial subjugation experienced by Native communities in both the United States and Canada involved the coercive cultural assimilation of indigenous youths in government-administered or church-run residential schools. Hundreds of these "total institutions" were established on both sides of the international border, enrolling tens of thousands of Native pupils over the course of a century. These industrial schools subjected children as young as 4 years of age to rote learning, inadequate nutrition, manual labor, Christian indoctrination, cultural assimilation, military-style comportment, and brutal corporal punishment (Adams, 1995; Miller, 1996). Indeed, one Canadian study of the impact of these schools on a First Nation community concluded: "Residential school students were overloaded with activities more appropriate to a correctional institution than a school . . . [and] could not be considered appropriate for learning, growth, and personal fulfillment" (Cariboo Tribal Council, 1991, p. 172). Not uncommonly, staff members at these schools engaged in horrific instances of violence and violation perpetrated against their wards, including sadistic acts of torture (e.g., "the repeated insertion of a hat pin into a child's rectum," Assembly of First Nations, 1994, p. 51).

In addition to violence, widespread loss of indigenous language, culture, and ceremony has combined with multigenerational disruptions in parenting practices to yield a harrowing legacy of distress and disability for contemporary Native peoples. Evidence of the adverse psychosocial correlates of the boarding school experience has appeared routinely (Corrado & Cohen, 2003). For example, one of the earliest systematic investigations of this legacy found that between one half and two thirds of respondents from a First Nation community assigned to the St. Joseph's Residential

School in British Columbia reported childhood experiences of sexual abuse (Cariboo Tribal Council, 1991). Brasfield (2001) has even proposed diagnostic criteria for a "residential school syndrome" that essentially contextualize and tailor the signs and symptoms of PTSD to the residential school experience of Native Americans. In Canada, the call for national redress and reconciliation has largely run its course, resulting in a national apology and the creation of the Aboriginal Healing Foundation (AHF). The AHF has disbursed federal funds to Aboriginal organizations and communities to redress the "legacy of physical and sexual abuse in the residential schools, including their intergenerational impacts" (*Funding agreement*, 1998, p. 7). In sum, proponents point to this bitter educational legacy as an exemplar of Native American HT.

Beyond its mandate to support healing projects financially, the AHF was also tasked with documenting the therapeutic activities of funded projects for posterity, principally because the extant literature concerned with community-controlled therapeutic programming for Native Americans is small. Moreover, rigorous assessment of therapeutic outcomes for such programs is virtually nonexistent (Gone & Alcántara, 2007). One explanation for this dearth of outcome studies is that although the culturally specific aspects of these programs feature prominently in their appeal, these are rarely described in sufficient detail to afford appropriately tailored outcome assessment. The research reported here includes analysis of the therapeutic approach—and especially the elucidation and systematization of the meaning of *healing*—within an outpatient counseling program as an inaugural exploration of the prospects for developing an EBT for locally salient HT in Native communities. In so doing, I hope to further illuminate the complexities and challenges of bridging EBT and CST approaches for Native peoples who increasingly attribute their problems to powerful intergenerational legacies of HT.

Method

The study described here was one of five coordinated research projects commissioned by the AHF. The purpose of these projects was to document therapeutic approaches and activities for a select number of AHF-funded programs intended to redress the legacy of the residential schools in Canadian Aboriginal communities. Selection of the programs was determined in consultation with the AHF to achieve representation across a range of geographical, cultural, and service delivery styles. More comprehensive description of these projects may be found in the official AHF report (Waldram, 2008). This study employs a discovery-oriented methodology—described by Bernal and Scharrón-del-Río (2001) as "exploratory, phenomenological, often qualitative, ethnographic, or naturalistic" (p. 336)—as a complement to the more familiar randomized controlled trials adopted in pursuit of EBTs. Whaley and Davis (2007) likewise applauded use of discovery-oriented methods in developing cross-cultural EBP.

Setting

This study explored the meaning of healing in a nationally accredited, First-Nation-controlled substance-abuse treatment center on a Northern Algonquian reserve (reservation) in Canada. I visited this healing lodge for 7 weeks between October 2003 and May 2004. The entire staff at the lodge identified as Aboriginal, and the supervisory board of directors was appointed by the local chief and council. Of the three programs administered by the lodge, the outpatient counseling program was the focus of the study. Funded by the AHF since 2000, the counseling program was designed to provide therapeutic services for the reserve community of some 2,400 resident members, most of whom were said by lodge staff to have been impacted by the residential schools. Although substance abuse features prominently in the lives of many residential school survivors, a wide range of additional problems was targeted by the program, including anomie, bereavement, relational problems, sexual abuse, and so forth. Supervised by the program coordinator, full-time counselors offered nightly lectures for program clients that served as the backbone of the 10-week program cycle. Lectures were supplemented by client engagement in individual counseling, community outreach, and cultural activities.

The therapeutic activities and techniques that structured treatment in this setting have been described elsewhere (Gone, 2008b, 2008c). A variety of Western therapeutic and Aboriginal cultural practices were incorporated into lodge activities, with an express commitment by staff to integrate these in the promotion of Aboriginal client well-being. Coherence in therapeutic approach across this diversity of techniques was attained through reference to the Aboriginal symbol of the medicine wheel. The medicine wheel—represented as a circle bisected into four interior quadrants—images the unity and harmony of four constituent parts (e.g., the cardinal directions, the races of humankind, or the experiential domains of human existence) even as it portrays the cyclical movement of time (e.g., the four seasons or the four stages of human development). As a result, the medicine wheel distinguishes treatment that expresses pan-tribal commitments to balance, harmony, and holism as key constituents of wellness. Moreover, promotion of the medicine wheel approach to healing simultaneously and self-consciously designates treatment efforts as overtly Aboriginal in character.

Participants

Interviews with 19 First Nation administrators, counselors, and clients—including all current staff—from the outpatient counseling program were completed for this study.

Administrators. The current and past executive directors of the lodge and the coordinator of the counseling program were interviewed for this study. In addition, a representative from the program's oversight committee was interviewed. All 4 of these individuals (3 were women; all were middle-aged) had earned 4-year college degrees and had worked extensively in human services settings, including longstanding involvement in lodge programs.

Counselors. All 4 of the individuals who had ever served as program counselors (2 were women) were interviewed for this study. Ranging in age from the early 40s to the mid-60s, 3 had personally experienced residential schooling, and one had been confined to a reform school during childhood. All were personally familiar with poverty, domestic violence, family disruption, sexual abuse, and addiction. All had contended with unmanageable lives before embarking on their own healing journeys. Two had obtained 4-year degrees in social work, and 2 had completed relevant college coursework.

Clients. Eleven clients, including 8 graduates of the program, were interviewed about their past participation in program activities. Seven of these respondents were men; 5 were in their 20s, 4 in their 30s, and 2 were older at the time of the interviews. Eight were single; only the 2 youngest men reported no children. Participation in the program was typically occasioned by longstanding chaotic life circumstances and accompanying distress (and was sometimes directed by the courts or social services). Two clients had directly experienced residential schooling, but all had parents or grandparents whose lives had been detrimentally impacted by these repressive institutions. Indeed, everyone on the reserve was deemed eligible for participation in the program because of this widespread intergenerational legacy. Although the client respondents represented perhaps half of the entire pool of program graduates over the years, they were likely *not* representative of the scores of clients who entered but never completed the program (precise tallies of program participants were not available). Program staff recruited respondents for participation in the study, with some interest in showcasing their most successful clients. Thus, this group was likely made up of individuals for whom the program was most helpful; their reflections on the program should be interpreted in this light (although for the purposes of this article, it seems unlikely that interviews with other clients would have substantially altered characterizations of the therapeutic approach promoted by staff).

Measures

Semistructured, open-ended interviews were designed for flexible administration by Waldram (2008). Using these interview protocols for counselors and clients, I first solicited extended respondent life narratives before embarking on additional questions about therapeutic matters during the second half of the interview. The counselor interview protocol contained 40 additional items pertaining to therapeutic training and practice (e.g., "What kind of training is needed to work with your clients?" and "How would you describe your [therapeutic] approach?"); the client interview protocol contained 45 items pertaining to therapist qualities and treatment experiences (e.g., "What makes [for] a good therapist?" and "What challenges do you face in your efforts to heal?"; for more items, consult Waldram, 2008). The program coordinator and committee member were interviewed in accordance with their training as counselors, whereas the other administrators were interviewed less formally in response to questions that arose during the study. All interviews focused on ascertaining the meaning of healing for staff and clients, on the basis of conversational give and take. Owing to time constraints, no respondent was asked every question in comprehensive fashion, but all respondents were engaged so as to reflect substantively on the major domains of interest. Interviews ranged between 30 and 210 min, with staff responses comprising the longer interviews. All interviews were recorded, transcribed, and verified for accuracy prior to analysis. Further contextualization of interview material was achieved through participant observation, review of program records, and consultation of relevant ethnographic publications.

Procedure

Community consent and approval by the controlling institutional review board were obtained prior to data collection. I conducted formal interviews whenever program staff members were able to transport former clients to the lodge for participation. All respondents provided written consent to participate in the interviews and were compensated with university-branded apparel. Only rarely did interviews require more than one session to complete (and only with staff). Summary descriptions of healing were obtained during the interviews from both staff and clients (e.g., "What is healing as you understand it?"), but one purpose of adopting open-ended interview protocols was to overcome the limitations of survey techniques to better understand the "webs of significance" that might afford thick description of healing in this setting (Geertz, 1973, p. 5). As a result, abstract summary descriptions of healing offered by respondents—though interesting in their own right—were just the tip of the iceberg. The interpretive challenge in this study was to anchor such descriptions within the broad sweep of interview responses such that additional elaboration, contextualization, and qualification of healing discourse (i.e., the formalized and orderly expression of practical knowledge) might afford additional insight beyond its most ready-to-hand qualities for respondents. In this regard, systematization and elucidation of this more nuanced and complete meaning of healing—including attributes and understandings that no individual respondent recounted in comprehensive or summary form—are among the chief goals of this article.

Following data collection, interviews were transcribed by hired assistants, yielding 379 pages of single-spaced interview text. I submitted these data to conventional thematic content analysis (Hsieh & Shannon, 2005) for induction of shared themes relative to the meaning of healing. Although the labor intensity of this analysis prohibited the enlistment of additional raters for triangulation purposes, confidence in the trustworthiness of inductive results for this study is supported by four considerations. First, the kind of thematic induction undertaken in this study was content based and dependent on plainly accessible respondent discussions of healing approach and activity. Thus, the need for interrater triangulation seemed to be minimal; certainly Geertz (1973) and subsequent generations of cultural anthropologists who have routinely engaged in thick description of cultural meanings have not relied on such triangulation (nor even on comprehensive transcription of interviews). Second, my intrarater dependability throughout these time-consuming analyses was structured by use of NVivo (Version 8), a qualitative data analysis software program used to code textual material and to interpret the hierarchical relationships between identified themes (Bazeley, 2007). More specifically, this program allowed me to highlight appearances in the transcripts of a comprehensive array of relevant search terms (e.g., for the emotional burdens theme, roughly 45 emotion- and problem-related words were highlighted on the basis of early precoding reviews of all transcripts) prior to thematic coding so as to ensure careful consideration of every textual instance in which a theme might be present.

Third, the interpretive turn within the social sciences (Rabinow & Sullivan, 1987) has yielded a host of methodological resources for engaging in qualitative methodologies (Denzin & Lincoln, 2005). In a recent overview of thematic analysis in psychology, Braun and Clarke (2006, p. 96) include a "15-point checklist of criteria for good thematic analysis" (including, for example, "all relevant extracts for each theme have been collated" and "themes are internally coherent, consistent, and distinctive"). Although

there is not space here to demonstrate this in any detail, I have attempted to ensure that all 15 criteria have been met for this study (and, interestingly, triangulation of derived themes through interrater consensus—perhaps for the reasons listed above—is not one of the stated criteria). Finally, on the basis of initial content analysis, a thorough descriptive report was drafted for the AHF and submitted to lodge administrators and counseling program staff for review and recommendations for improvement. Reaction to the report included suggestions for improvement that were readily incorporated, none of which pertained to the kind or quality of themes themselves. Inasmuch as one goal of interpretive analysis of this sort is to engage the reader as a "co-analyst" of the data (Erickson, 1986), this official report (Gone, 2008b; available at http://www.ahf.ca/publications/research-series) comprises a comprehensive archive of project data, preserving details of both method and results that more realistically afford interested readers an opportunity for coanalysis of the data. Most recently, an earlier version of this article was submitted for staff review as well, eliciting an enthusiastic response (E. Azure, personal communication, October 27, 2008).

Results

Four primary themes emerged from interview data with regard to the meaning of healing. These themes were labeled *emotional burdens*, *cathartic disclosure*, *self-as-project reflexivity*, and *impact of colonization*. Relevant facets of these themes are reviewed briefly insofar as they together comprise the local healing discourse. Not surprisingly, counselors were more articulate than clients with regard to the meaning of healing; as a result, this analysis tends to center on counselor responses. Finally, in the interest of preserving respondent confidentiality, pseudonyms have been adopted for attribution of interview material: Administrator pseudonyms begin with *M*, counselor pseudonyms begin with *T*, and client pseudonyms begin with *A–K*.

Emotional Burdens

A fundamental principle of the healing discourse in the counseling program was that individuals in need of therapeutic attention were contending with unmanageable and chaotic lives—including substance abuse—owing to enduring legacies of personal pain. Nine of the clients described painful personal experiences during their interviews, and the remaining 2 alluded indirectly to such "burdens." Frequently these experiences occurred early in life, usually in the context of family relations or other custodial care. One local exemplar for these sorts of experiences was the mistreatment endured by children in church-run residential schools:

> [The residential school] is where I encountered all forms of abuse. . . . The form of discipline [the priest] used to give us was physical discipline. Used to get strapped. . . . We used to run away, too. I was trying to run away from that pain. We were trying to run away from the way we were treated. But when we . . . were caught, they used to shave our head. . . . I'm the victim of sexual abuse, too, by the priest. . . . I couldn't study and I couldn't concentrate across all that pain I carried there. (Ann, client)

Prior to her school years, this client was reared in a hunting camp. It seems likely that the labors of the hunt, including the transport of meat, gave rise to the metaphor of "carrying" pain.

The weight of such emotional burdens was identified as the etiological source of personal problems later in life. Sometimes onset of troubled behavior was almost immediate:

> After coming out from residential school, we all turned to alcohol. My sister drank and drank. Her kids were taken away. . . . She had the cirrhosis 2 years ago. . . . Last summer, she ended up in the hospital again. She was in a coma. (Tess, counselor)

In other instances, such burdens were shouldered for decades:

> I carried my sexual abuse for 40 years before I was able to talk about it. . . . A lot of our Native people today are carrying a lot of heavy, heavy stuff that you can't unload. Then we wonder why you turn to alcohol. That's the reason I turned to alcohol: to numb the pain. . . . Oftentimes right away we label [people's problems], "Well it's an alcohol problem." . . . That person has an alcohol problem for another reason. (Tom, counselor)

The metaphor of a pressure cooker was also used to describe pain and its consequences:

> Because of those [abusive] experiences, a lot of them never recovered. A lot of them had turned to alcohol as a means of escape. A lot of them didn't get the counseling they needed. . . . They never dealt with their issues. . . . They kept it inside. Then it just built up like a pressure cooker. (Marge, administrator)

Thus, substance abuse was routinely recognized as merely one symptom of a deeper problem: "There's always a reason why people drink: because they carry pain" (Tia, counselor).

Moreover, in the absence of therapeutic remedies, such burdens were seen to harbor the potential to impact individuals in deleterious ways throughout their entire lives:

> We take the former students from our community to their [residential] schools. . . . We have people that won't even want to go . . . , that can't open up. Whatever happened over there, they just as soon leave it over there. But the thing is, it doesn't stay over there. . . . That's what they have to realize: that it doesn't go away until they deal with it. Face it head on. . . . People have gone to their graves with . . . a lot of pain. (Ted, counselor)

Indeed, it is this potential for lifelong suffering that gives rise to the therapeutic imperative:

> I had a panic attack . . . . I think it was what I read [about child abuse] that triggered . . . all the abuse that I had endured. . . . I needed to start to deal with my own issues. . . . It was a nurse who told me, "There's nothing physically wrong with you. You need to deal with whatever happened to you . . . . Get some help. . . . Go see a psychologist." (Tia, counselor)

Thus, the value of the counseling profession was seen to inhere in the promise that emotional pain from childhood—though formidable in its effects—need not consign one to a life of misery.

In sum, a key component of the healing discourse in the counseling program was that clients and community members in need of healing were suffering from past personal pain—often from early childhood experiences, such as abuse of various kinds—that continued to debilitate or derail their lives in the present. Addiction was recognized as a chief consequence of this pain. Absent one's willingness to deal with such pain (i.e., to "face it head on"),

associated distress and dysfunction were expected to disrupt one's life into the foreseeable future.

Cathartic Disclosure

If past personal pain harbored the potential to disrupt individual lives, then the therapeutic imperative (i.e., "get some help") offered assurances that individual recovery was indeed possible. Thus, a second principle of healing discourse within the counseling program was that clients and community members could find relief from their emotional burdens by dealing with their pain through acknowledgement and verbal confession of past ordeals. The entire staff celebrated and promoted the therapeutic effects of cathartic self-expression:

> It was a process where they took me back into my childhood to actually look at [my trauma]. And reopen it in a calm, safe environment. . . . I was safe to be able to look back into my childhood, and go see what had happened, and to let it go. (Tia, counselor)

Another counselor described personal disclosure of sexual abuse that he had carried for years:

> I find that pain . . . is buried inside you. . . . If you disclose it, it's your healing. . . . But if you bury it, and don't want to say nothing about it, then it's going to affect your life. . . . There's an exercise in social work training that we were doing. . . . Something dug way down inside and triggered for me to just bluntly disclose [my sexual abuse]. . . . I just got very emotional. . . . After[ward], I could have . . . flew over the building. (Ted, counselor)

Metaphors such as letting go, opening up, or digging out were characteristic of this emphasis on the disclosure of painful and potentially shameful experiences from one's past.

Furthermore, as part of their own healing journeys, counselors were encouraged to recount these experiences for the benefit of themselves and others within therapeutic settings:

> I'm on my healing journey, too, by letting out my stuff. Before, I used to have a very difficult time to speak in public. I was very emotional. I've been sexually abused, myself, and I guess that's why that part of it all built up inside me. That's why I got so emotional to talk. . . . So the next day, I gave it another try. It was much easier. (Tess, counselor)

Moreover, they aspired to orchestrate these same kinds of cathartic disclosures by their clients:

> [Our clients] just can't bring themselves to talk about [their pain] in public. In that [therapy] group. But sooner or later they realize that they'll have to talk about it in order to address it. . . . Once they do that, then they're okay with it. (Tom, counselor)

Thus, whether in group or one-on-one counseling, clients were expected to disclose personal pain as part of their recovery. One counselor said it best: "A lot of . . . people [out] there need . . . counseling. Talk to [Ted]. Let's dig it out. . . . Let's begin our healing journey" (Ted, counselor).

The therapeutic imperative to talk evidently took root, as all but one of the clients cited or expressed this central principle during the interviews. One client explained as follows:

> It's good to talk about things that you normally can't talk about. . . . It's just the release of the tension or the burden that you're carrying . . . . Sometimes I thought [domestic abuse] was my fault. . . . Then I talk about it. But when I cry, it releases it. (Beth, client)

Another client described her experience during a grieving exercise facilitated by the counselors:

> In this one session we did, you had to write a letter to a loved one that had passed away. I wrote to my mom. I told her I'm sorry I wasn't there for her the day she died. . . . I read it out loud [to everyone]. Something lifted out of me. . . . I just felt so good. (Clare, client)

A third client expressed gratitude that his counselor had encouraged him to speak about his pain:

> [That group] taught me how to . . . express how I really felt inside me and bring [my sexual abuse] out. That really helped. It took a lot of weight out of my shoulders, and I felt lightened after that, when I was finally able to cry in front of people. (Ed, client)

Given the centrality of cathartic disclosure in both counselor and client interviews, it would be difficult to overestimate the perceived power of talk to purge personal pain in this setting.

In sum, a key component of the healing discourse in the counseling program was that painful burdens that were disrupting one's life might be lifted, relieved, or released through verbal confession and emotional catharsis. Therapeutic facilitation of this cathartic disclosure was a primary objective of both group sessions and individual counseling. Although those in need of healing might resist the invitation to recount such distressing experiences, failure to do so was seen as the inability or unwillingness to begin the healing journey.

Self-As-Project Reflexivity

As central as the purging of personal pain was to the healing discourse of the counseling program, no respondents suggested that emotional release was the sum total of healing. Rather, these dramatic instances of confessional expression were instead expected to initiate a life-long process of habitual introspection and evolving reflexivity that actively construed the self as a *therapeutic project.* Thus, counselors endeavored to help clients look inward:

> This [client] would reveal to me what it is that they're feeling. . . . It's important to ask why. Because oftentimes I think in our . . . trying to make sense of the problem, we forget to ask why. . . . When we look at things from a different perspective . . . we can have a clearer picture, and to be able to identify what . . . the real problem is. (Tom, counselor)

The benefits of looking inward were apparent to this counselor, based on his own experience:

> One time a person [asked] me why I drank. . . . I realized that it was to numb the pain. This pain of my sexual abuse. This pain of my residential school experience. . . . When I was able to address the real issue, then I realized that I don't need this [alcohol]. (Tom, counselor)

Thus, self-examination was understood to yield insight (or "realizations") into the true (or "real") nature of one's problems that could be harnessed for the alteration of destructive behavior.

Moreover, the awareness gleaned from the introspective process (i.e., looking at oneself) was deemed necessary for the longer term therapeutic objective of refashioning the self in transformative ways throughout one's life (i.e., "working on" oneself):

> Over time, when I got to working on myself and getting better, getting well, it became easier . . . because [then] I could honestly talk about meaningful issues. (Tom, counselor)

An administrator elaborated on this principle in describing her own development as a counselor:

> I started working with the . . . traditional people to . . . become a better human being. And to be able to see . . . I'm not to blame. . . . After I started working on myself, I promised . . . that I'd have that . . . paper saying that I'm [a therapist]. (Meg, administrator)

Another administrator recognized this remaking of the self as central to the lodge's mission:

> [The lodge is] a place to heal. It's . . . a place where [clients] can get the support [they need]. . . . To encourage their own personal development. . . . Providing the supports for people that want to work on themselves. (May, administrator)

In short, learning to consider oneself as a therapeutic project, always in the making, was an important outcome that staff attempted to orchestrate for clients within the counseling program.

Once again, all but three of the clients made at least passing references to greater self-awareness, self-understanding, and self-transformation—albeit with much less elaboration than their counselors—as a consequence of their participation in the counseling program:

> When they started this lodge here . . . I thought it was only just to maintain your sobriety. . . . But little did I know that I had to go further. To have that healthy lifestyle you've got to look at your attitude, your thinking, your behavior. You've got to look at yourself . . . in order to have that balance. (Ann, client)

A second client focused less on the looking and more on the working aspect of treatment:

> One thing this program's taught me is . . . that this day's not the end yet. I don't really have to worry about tomorrow because it's not here yet. Yesterday, I can't really do nothing about it, because it already happened. It's to live that I have to work on. (Ed, client)

A third client referenced his shift in perspective quite simply:

> [My counselor] said something that hit me good. Something like, "You're here now. What you did in the past is over with. Try to think about the future." So it's relieved me. Like before I used to worry about my past life. . . . Now I just forget about it. (Hal, client)

No matter how limited the degree of transformation that was reported by clients, most recognized beneficial alterations in their perspective and understanding as a result of treatment.

In sum, a third principal component of the healing discourse in the counseling program was that positive self-transformation followed in the wake of learning to peer inward so as to better understand oneself, one's life, and one's behavior. Armed with novel insights, clients were empowered to commence the remaking of themselves through lifelong habits of introspection and self-examination that effectively construed the self as a therapeutic project in need of regular attention, cultivation, and effort. Thus, the healing journey itself was described as this lifelong process of conscientious self-engagement, designed to achieve wellness and fulfillment.

Impact of Colonization

In the healing discourse of the counseling program, the therapeutic importance of reflexive orientation was counterbalanced by a simultaneous emphasis on placing one's life and experiences within the broad sweep of Aboriginal community and history. Thus, in addition to learning to acknowledge and express personal pain as part of a long-term refashioning of the self, healing further entailed a reconceptualization of one's life and experience as an Aboriginal person in the context of European Canadian colonization. For this program, the most salient expression of colonization was the residential schools. Beyond the apparently widespread instances of neglect, exploitation, and brutality in these schools, the long-term existential and spiritual consequences of Aboriginal cultural suppression featured prominently as well:

> I lost my culture. . .. When I attended the university, that's the first time I saw a powwow. . . . I never used to see sweat [ceremonies]. . . . It's only now [that] I start learning my culture, half a century [later]. . . . I didn't know the meaning of the symbolics of our culture. Instead, I know the symbolics of the Catholic faith. (Ann, client)

This client expressed a central and recurrent theme among Aboriginal survivors of residential education, namely the loss of language and culture that has left so many Aboriginal people bereft of their unique place in the world. It is these disorientations and their psychosocial correlates—achieved by more than a century of government policy affecting tens of thousands of Native people across hundreds of reserve communities—that the term HT was intended to capture.

The concrete impact of colonization on the lives of community members was self-evident to many on the reserve. One client allowed that, although she lived in beautiful surroundings, much had gone wrong in the community: "Murdering, kidnapping, drugs, break-ins, beating people up, robbing them." When queried as to the origins of these devastating problems, her reply was direct: "From the Western society. Colonizationists. Europeans" (Beth, client). Of course, the residential schools were not the only source of devastation for tribal members. Other governmental policies that yielded adverse consequences for the community were noted as well, including the flooding of traditional hunting grounds for generation of hydroelectric energy:

> I'd seen a bit of drinking back then but it wasn't so bad. . .. It was beautiful out [on the land]. But then I started noticing . . . the water rising. I heard elders and older men talking about Hydro. . . . The land was going to get flooded. . . . My parents started drinking. . . . As the water was rising, I think there was sort of a grief and loss because . . . I heard my father complaining about what Hydro was doing to . . . their trapping grounds. (Ed, client)

Thus, beyond the injuries of cultural suppression and coercive religious conversion, many Aboriginal people from this reserve subsequently lost their material livelihood as a consequence of

provincial policy as well, the deleterious impact of which would be difficult to overstate.

Although only three clients made overt links between personal distress and colonization history, staff members in the counseling program insisted that overt consideration of culture, history, and identity were absolutely central to the healing process for Aboriginal people. As one administrator stated: "Healing is going to take time because there's so many things that [our people] have to relearn. They have to relearn their culture" (Marge, administrator). When queried as to why healing requires a return to Aboriginal cultural practices, she explained:

> [Our people] have a culture, [and their healing] should be based on that . . . because a lot of our people . . . were brainwashed to . . . believe that their . . . traditional practices were evil. . . . So, with our people, that's why identity's really important. They need to be proud of who they are . . . to become united and healthy as a nation. Our people need to relearn their cultural practices and traditions, in order to be proud of who they are. . . . That's why the healing has to be unique. . . . We wanted to make [our lodge statements] unique to the Aboriginal. . . . We don't want a vision statement that any white person can use. We want it to be unique . . . so that . . . they'll know it's an Aboriginal vision. (Marge, administrator)

Healing, then, was understood to involve much more than mere treatment for one's problems. Instead, healing also entailed a spiritual revitalization of indigenous orientations and practices that was deemed necessary not just for program clients but also for the entire tribal community.

In sum, a final major component of the healing discourse in the counseling program was the contextualization of personal pain and dysfunction within the shared Aboriginal history of European Canadian colonization. As a result, healing was seen to entail much more than the mere amelioration of personal distress and promotion of individual coping. More specifically, a robust *postcolonial* Aboriginal identity—attained in part through the contemporary reclamation of indigenous cultural and spiritual practices—was promoted by program staff as the primary means to remedy the shared legacy of HT that continued to afflict the reserve community.

The Meaning of Healing

In assembling the four principal components that were induced from interview data, healing for the staff and clients in the counseling program was determined to mean: an unfolding process of self-transformation—characterized by an acknowledgment of past personal pain, dealing with one's problems through disclosure and catharsis, looking at oneself through consistent introspection, working on oneself toward improved self-understanding, and finding one's purpose as an Aboriginal person—that reorients and motivates vulnerable and wounded selves toward renewed and meaningful engagement in the world. This expansive vision of healing is what sustained these respondents during their program participation, comprehensively bridging past and present, self and community, psyche and spirit, and the indigenous and the global.

Discussion

Interpretive analysis of the meaning of healing was undertaken among the staff and clients of an outpatient counseling program in an accredited Northern Algonquian healing lodge. The purpose of this analysis was to explore the prospects for bridging the commitments of EBT and CST approaches in the context of Native American HT. In contrast to proposals that intervention researchers should start with established EBTs and subsequently tailor these for diverse ethnoracial minority clienteles prior to rigorous outcome evaluation (Hall, 2001; Whaley & Davis, 2007), this study adopted an alternative approach to exploring this complex issue. Specifically, this article has taken as its point of departure the consideration of an actual on-the-ground therapeutic approach adopted and promoted by Native practitioners in their attempt to meet what they see as the culturally distinctive therapeutic needs of their own community. Thus, rather than commencing with an established EBT, this analysis starts with an existing CST and wonders what insights might be gained about the complexities and challenges confronting cross-cultural therapeutic outcome assessment in multicultural societies. Based on this complementary approach, four insights regarding the EBP movement in psychology are discussed in turn. These insights draw on the limited culture and psychology literature for Native Americans as well as my 15 years of professional and research experience in these communities.

The first insight with regard to the bridging of EBT and CST commitments in light of actual therapeutic practice at the Lodge pertains to the formulation of the disorder to be remedied. Proponents of EBTs assume that treatment outcomes are most usefully assessed for technique-by-disorder pairings (e.g., exposure and response prevention for obsessive compulsive disorder). But in the Northern Algonquian context, as in many other Native communities within Canada and the United States, HT—including the psychosocial legacy of the residential schools—does not synchronize with the reigning constructs of psychopathology (Brave Heart, 2003) in content, form, or function. Brasfield's (2001) proposed criteria for residential school syndrome notwithstanding, there are no consensually accepted diagnostic criteria for HT. Indeed, judging by the widespread popularity of this concept absent its formal investigation in Native communities, reliable and valid assessment of HT appears never to have been a pressing issue. Rather, the overarching discursive agenda of HT proponents was to politicize and historicize "social pathologies" or "personal problems" among Native peoples in light of the enduring all-too-real consequences of colonization, oppression, and injustice inflicted and sustained by surrounding settler societies (E. Duran & Duran, 1995). The goal, then, was to highlight systemic factors (e.g., coercive assimilation) alongside intrapersonal factors (e.g., maladaptive coping) and to accentuate shared community vulnerabilities (e.g., the suppression of Aboriginal lifeways) more than individual deficits (e.g., impulse control). The intended effect was to neutralize the paralysis experienced by community members by attributing individual distress to shared historical oppression rather than personal failure (Caplan & Nelson, 1973).

A second insight with regard to the bridging of EBT and CST commitments in light of on-the-ground therapeutic practice pertains to the proposed remedy for the disorder in question. Again, proponents of EBTs assume that treatment outcomes are most usefully assessed in terms of conventionally prescribed indicators of symptom amelioration and improved functioning (e.g., reduction in posttreatment symptom scores). But in the Northern Algonquian and other Native community contexts, the therapeutic

emphasis frequently remains on healing rather than on treatment. For Native peoples, holistic healing typically differs from medical treatment in its scope, its source, and its effects (Morse, Young, & Swartz, 1991). In contrast to the targeted scope of treatment, Native healing moves well beyond mere clinical concerns with distress and coping toward a more robust state of wellness, as indicated by strong Aboriginal identification, cultural reclamation, spiritual wellbeing, and purposeful living (McCabe, 2007; McCormick, 2000). In contrast to the secular origin of treatment, Native healing assumes that human ingenuity and empathic technique are inadequate to the task of transforming Aboriginal selves relative to ceremonial activities that access spiritual power from other-than-human beings (Gone, 2007, 2008c, in press). In contrast to the expected effects of treatment, Native healing assumes a range of possible outcomes that frequently limits the a priori specification of predicted results in mechanistic terms (Mohatt & Eagle Elk, 2000).

A third insight with regard to the bridging of EBT and CST approaches pertains to the nature of the evidence required for the appraisal of therapeutic outcomes. Proponents of EBTs adopt scientific methods to isolate causal relationships between intervention and outcome in the context of regulated professional expertise. But in the Northern Algonquian and other Native community contexts, there exist enduring traditions that situate epistemological authority within firsthand experience, alongside much greater openness to explanatory accounts that invoke the numinous (Darnell, 1991). The result is a complex set of epistemological divergences concerning how one knows whether therapeutic interventions have worked (Gone & Alcántara, 2007). The primacy of personal experience in Native communities implies that the testimony of either counselor or client (or both) may already be considered to have met the highest standard by which efficacy might be assessed (and, indeed, none of the lodge staff ever expressed interest in formal assessments of their efforts). Moreover, the perceived spiritual nature of healing complicates evaluation insofar as the assumption of mechanistic cause and effect is often rejected in favor of much less predictable and mysterious processes that remain fundamentally interpersonal (whether among human persons, or between human and other-than-human persons; Morrison, 2000). As a result, formal outcome assessment of therapeutic interventions is seen by many Native people as an irritating distraction, one that siphons resources away from the provision of more or better services (indeed, during intermittent discussions, lodge staff conveyed no interest in EBTs for substance use, nor in any nonspiritual treatments [Gone, 2008c]). The point here is not whether scientific methodology in fact transcends other human ways of knowing but simply that its promotion in these contexts is likely to be met with resistance to the imposition of yet another West-is-best ideology addressed primarily to narrow outsider interests, even as it threatens local epistemologies (B. Duran, Duran, & Brave Heart, 1998).

A final insight with regard to the bridging of EBT and CST approaches in light of actual therapeutic practice pertains to the overarching political agenda served by healing vis-à-vis treatment in contemporary Native communities. Proponents of EBTs promote their interventions simply because these are acknowledged—in light of rigorous outcome evidence—to afford the best chance for professionals to benefit clients who have sought psychological services for relief from distress. The primary political objective of the EBP movement in psychology is thus simply to deliver on the professional promise of actually helping clients in need of efficacious services. In contrast, the political objective of Native healing offered through distinctively Aboriginal therapeutic services is typically much more ambitious. More specifically, these services figure rather prominently in a comprehensive, community-based *decolonization* agenda (E. Duran, 2006; Mussell, 2008). Decolonization is the intentional, collective, and reflective self-examination undertaken by formerly colonized peoples that results in shared remedial action. Such action traces continuity from "traditional" (precolonial) experiences even as it embarks on distinctive, purposeful, and self-determined (postcolonial) experiences. The key to decolonization is community emancipation from the hegemony of outside interests (Wilson & Yellow Bird, 2005). Although the prospects for decolonization in Native North America remain fraught with challenges, contemporary tribal communities have made recognizable progress in reasserting authority and wresting control from settler society governments in multiple domains, including tribal administration of therapeutic services (McFarland, Gabriel, Bigelow, & Walker, 2006).

The present study affords opportunity for professional psychologists to re-examine the divergent concerns and commitments of EBT and CST proponents in a new light. By highlighting the differences between EBP and Native American healing, I hope to make the significant and substantive reasons for these divergences more apparent to a broader disciplinary audience. Pursuit of this objective has precluded exploration of other analytical domains. For example, the emphasis on disclosure and catharsis of childhood pain bears some resemblance to exposure treatment for PTSD, the efficacy of which has been experimentally supported (Chambless & Ollendick, 2001). Moreover, the centrality of the twelve-step approach to recovery from alcoholism in this setting at least suggests that the handful of EBTs for alcoholism (McCrady, 2000) might gain traction among the staff, particularly if these could be incorporated alongside the range of highly valued spiritual approaches such as the twelve steps and Aboriginal ceremonies (Gone, 2008c). Indeed, to the degree that indigenous decolonization efforts remain open to select Western approaches and techniques, it remains at least possible that the adaptation of EBTs—assuming efficacy is maintained—may actually further these worthy efforts. In other words, the simple fact that EBTs were not in practice in this setting does not necessarily imply that these would be deliberately excluded under all circumstances, and future efforts to bridge EBTs and CSTs in community practice might prove illuminating.

Another limitation of the study includes the low number of program clients who were available for interviews, and especially the fact that client respondents were disproportionately recruited from the ranks of program graduates. In light of this sample bias, how might interviews with a more comprehensive range of clients—including the vast majority who never completed a 10-week outpatient program cycle—have impacted the conclusions of this study? It seems probable that clients for whom the program did not take would have been less likely to endorse the principal components of healing discourse at the lodge identified here, in comparison to participating staff and clients who did complete formal interviews. Insofar as healing discourse was largely staff-driven within this setting, potential nonendorsement of this discourse by

clients who did not complete their treatment is difficult to confidently interpret in the abstract. Indeed, failure to achieve program graduation could be attributed to a wide range of factors: Such clients might have suffered greater distress and disability that undermined their ability to embark on their healing journeys; alternately, they might have actively rejected particular aspects of healing discourse as culturally or personally irrelevant. Although client rejection of healing discourse remains an intriguing possibility, additional interviews with clients who did not graduate from the program would have been necessary for exploring such possibilities empirically. Future studies of CSTs would likely benefit from attention to participants for whom the intervention has appeared to not work. Finally, an additional possible limitation was the degree to which the therapeutic discourse at the lodge might generalize to other Native American community treatments (although such discourse would be recognizable to all of the tribal communities with which I am professionally familiar).

Despite these limitations, the foregoing insights remain grounded in the actual therapeutic discourse of a Native-controlled healing setting. What then might be concluded regarding the professional call to bridge EBT and CST commitments? Perhaps the single most significant oversight of the prevailing approach is that incremental modifications of established EBTs fail to address several divergent political and cultural commitments of ethnoracial minority constituencies, such as the examples just reviewed. After all, the substance of the multicultural critique within the profession is not that the culturally different are simply "uncomfortable" with mainstream EBTs, such that merely adorning these approaches in cultural garb (a few beads here, some feathers there) might remedy the problem. Instead, the real danger is that these approaches partake of European American cultural norms, presume specific forms of personhood, and socialize clients into particular kinds of lived experience (Kirmayer, 2007; Meehl, 1959). That is, by virtue of their own cultural assumptions and expectations, these interventions may well purchase amelioration of symptoms or improvement in functioning at the expense of tacit Western cultural assimilation (Gone, 2008a). As this analysis of healing has demonstrated, Native communities can depart substantially from the cultural templates undergirding EBTs when allowed to administer their own therapeutic programming, even when such approaches are institutionally constrained by the training, credentialing, and accreditation requirements placed on treatment providers and settings. As a result, the outside limits of a more fully decolonized approach to Aboriginal healing have yet to be established within Native community contexts.

How might the gap between EBT and CST commitments be more fruitfully bridged by intrepid outcome researchers? Alongside evaluation of established EBTs that have been incrementally adapted for ethnoracial minorities, additional broad-minded and open-ended collaborations must be simultaneously pursued between intervention researchers and minority-controlled therapeutic settings. More specifically, the complementary strategy of exploring outcomes for CSTs already offered in these communities should be initiated under the close direction of community members. This approach would address the multicultural critique more thoroughly by virtue of recognition that evidence is never obtained in the absence of specific interests and acknowledgment that the interests that govern and guide the EBT movement in psychology are narrow relative to, say, those that inspire and sustain culturally grounded, community-based, decolonization efforts. In this alternative vision for bridging EBTs and CSTs, psychologists serve as consultants to the community, pursuing evidence of therapeutic outcome that sets aside the largely professional fascination with internal validity and controlled trials in exchange for taking up the local desiderata of communities (Gone, 2007, 2008c). Suddenly, outcome assessment becomes locally relevant, tailored concurrently to serving the pressing interests and needs of the community as well as providing potential support and legitimacy for grassroots therapeutic alternatives. Much stands to be gained from and for minority treatment settings under such circumstances, in which the very preservation and practice of cultural and spiritual traditions might come to be venerated as valid therapeutic outcomes in their own right.

Conclusion

The meaning of healing among the staff and clients of a Native American community-based counseling program was analyzed from interview data. The program was established to address a salient form of Native American historical trauma, namely the harmful psychosocial legacy of the Aboriginal residential schools. Four components of healing discourse emerged from these data. First, clients were understood to carry childhood pain that led to adult dysfunction. Second, such pain was to be confronted and confessed if relief was to be obtained. Third, this cathartic expression was seen to inaugurate a healing journey of lifelong introspection and self-improvement. Finally, this healing journey entailed reclamation of indigenous heritage to remedy the damage of European colonization. This healing discourse served as a way to reconsider how best to bridge EBTs and CSTs. In addition to ascendant recommendations that established EBTs should be incrementally adapted for the culturally diverse, concurrent collaboration of research psychologists and community partners was proposed in pursuit of evidence for emergent therapeutic alternatives in direct response to local interests and needs.

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