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American Indian Culture as Substance Abuse Treatment: Pursuing Evidence for a Local Intervention

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Abstract — Contemporary tribal commitments to traditional cultural reclamation and revitalization find continued expression by recent generational cohorts of American Indians who, when it comes to matters of recovery, healing, and wellness in the context of substance abuse, routinely assert that "our culture is our treatment." And yet, empirical investigations of this culture-as-treatment hypothesis—namely, that a (post)colonial return to indigenous cultural orientations and practices is sufficient for effecting abstinence and recovery from substance use disorders for many American Indians—have yet to appear in the scientific literature. Preliminary activities of a research partnership dedicated to the empirical exploration of this hypothesis for reducing Native American substance use disorders are summarized. Specifically, collaboration between a university-based research psychologist and a reservation-based substance abuse treatment program staff has thus far resulted in a detailed blueprint for a radically alternative, culturally-grounded intervention developed for reservation residents. This proposed alternative intervention—a seasonal cultural immersion camp designed to approximate the day-to-day experiences of prereservation ancestors—was designed for eventual implementation and evaluation with adult clients referred for residential treatment on the Blackfeet Indian reservation. It is anticipated that the proposed intervention will eventually afford empirical evaluation of the culture-as-treatment hypothesis.

Keywords — American Indians, culture, evidence-based practice, participatory research, substance abuse, treatment

For centuries, Euro-American observers have noted the disruptive effects of alcohol use in American Indian (AI) communities (Leland 1976). Current research demonstrates that such problems endure in many quarters of tribal America today. For example, among a large sample of southwestern AI men, the lifetime prevalence of alcohol dependence was estimated at 70%, among the highest ever reported (Kunitz & Levy 2000). Using more rigorous population-based sampling methods, Spicer and colleagues (2003) found lifetime prevalence rates of 20.5% for AI women and 30.5% for AI men from a northern Plains reservation (in comparison to rates of 8.2% and 20.1% for adult Americans). The inclusion of alcohol abuse, as well as other drug abuse and dependence, yielded lifetime rates of substance use disorders (SUDs) for this same population of 31.0% for AI women and 43.1% for AI men

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(Mitchell et al. 2003). Statistics fail to convey, however, the decimation that SUDs have wrought in these close-knit communities, where identification with large extended families normatively entails considerable kinship obligation. As a result, for many AI communities, literally no one is left untouched by the scourge of SUDs (and associated adverse sequelae, such as diabetes, heart disease, cirrhosis, accidents, injuries, and suicides). Thus, AI access to efficacious treatment is imperative and urgent.

Although the scientific literature examining SUDs treatment outcomes for AIs is extremely limited (a May 2011 search in the PsycInfo bibliographic database exploring the intersection of three designated "major descriptors"—AIs/Addiction/Treatment—yielded just four articles), researchers and clinicians who work in tribal communities routinely deem treatment-as-usual for AIs with SUDs as strikingly ineffective. Within AI communities, treatment-as-usual frequently involves Minnesota Model residential care (ranging from 30 to 120 days) organized around the 12 Steps of Alcoholics Anonymous (AA); many of these programs are administered directly by tribal governments with federal funds. And yet, throughout "Indian country," it remains an overwhelming challenge to persuade tribal members with SUDs to enter residential treatment, motivate AI clients to complete the prescribed duration of treatment, equip AI clients to maintain sobriety upon return to community life, and inspire AI clients to pursue meaningful and fulfilling lives without substance use. Consensus among tribal authorities, researchers, and practitioners alike has coalesced around one prevalent explanation for the failure of professional services to meet the SUDs treatment needs of AIs: *culture*.

More specifically, knowledgeable advocates in tribal communities routinely identify conventional treatment services as culturally discordant and therefore experientially alienating for many reservation-based AIs. Culture-based interpretations of AI SUDs treatment failure are supported by the literature. For example, in one study, AIs with a variety of psychiatric problems expressed preferences for "traditional" informal services instead of formal medical services (Walls et al. 2006), and in another study were as likely or more likely to consult traditional healers for help in comparison to actual behavioral health professionals (Beals et al. 2005). Although the reasons for AI reluctance to participate in counseling have not been well studied, one plausible explanation is the "western" cultural assumptions that undergird modern counseling. Kirmayer (2007) characterized psychotherapy as a form of psychic healing that relies on psychologically-minded, self-referential talk to achieve therapeutic change. The primacy of therapeutic expression is, in turn, premised on a western cultural concept of the self as agentic, rationalistic, monological, and univocal, and the western notion of personhood as egocentric and individualistic. In short, to participate in counseling—including the therapeutic activities that prevail in Minnesota Model SUDs treatment—is to embrace the "talking cure" in service to personal transformation.

And yet, cultural anthropologists have been routinely impressed by cultural norms in many AI communities that proscribe such expressive talk outside truly intimate circles (Basso 1990; Darnell 1981). Nevertheless, the emphasis on therapeutic expression within the counseling endeavor is so pervasive that even self-conscious efforts by AI staff in SUDs treatment programs to "indigenize" their services still prioritize the talking cure (Gone 2009, 2011b; Prussing & Gone in press). Because AI clients who engage in substance abuse treatment do not typically sign on for tacit western cultural assimilation, the challenge is to develop innovative interventions that will fortify rather than displace AI modes of life experience. Most significantly, AI treatment participation must not mandate learning to construe and communicate one's feelings in the western individualist and expressive modalities of "therapy culture." Thus, the problem of culturally incommensurate treatment addressed in this article involves an inversion of the usual approach to ensuring "cultural competence." Rather than merely adapting existing, mainstream evidence-based interventions for cultural appeal to AI clients (Wendt & Gone in press), we propose a novel intervention—designed from the cultural ground up—for purposes of scientific evaluation that could result in a locally emergent, evidence-based substance abuse treatment for AI clients (Gone 2011a).

FORMULATION OF A CULTURALLY-LOCAL INTERVENTION

As a result of a collaborative research partnership described in this article, we propose a novel intervention—namely, a structured indigenous cultural immersion program—designed together by the authors with other tribal participants to reduce SUDs among adult AIs referred for residential treatment on the Blackfeet Indian reservation. The Blackfeet Nation is a federally-recognized AI tribe that retains a sizable reservation adjacent to Glacier National Park in Montana. Home to some 15,000 tribal members, the reservation contends with severely limited economic resources and intransigent poverty. Although many tribal members completely abstain from substance use, a sizable minority struggle with alcohol, marijuana, methamphetamine, and prescription drug dependence resulting in alarmingly high rates of violence, trauma, injury, despair, suicide and other premature deaths associated with SUDs. The Crystal Creek Lodge, a nonprofit, federally-funded, tribally-administered SUDs treatment program, is tasked with managing this overwhelming disease burden. Located in Browning, Montana, the Lodge is the only licensed, accredited tribal program to provide residential SUDs treatment in the state. Lodge

clients obtain residential treatment at no personal cost, although roughly as many clients enter treatment by court order as enter voluntarily.

Lodge programs include residential, outpatient, and referral components serving adults and adolescents from an exclusively AI population, the majority of which is Blackfeet by citizenship or descent. Residential treatment at the Lodge represents a local adaptation of the AA-based Minnesota Model. Within recent years, availability of the Lodge's 20 treatment beds has usually kept pace with demand; the more difficult challenges include persuading clients to complete treatment, and equipping clients to maintain sobriety once they are discharged. Given the prevalence of poverty and unemployment throughout Montana's AI communities, many clients return to circumstances more conducive to SUDs than recovery. In consequence, residential treatment has proven extremely limited in producing desired outcomes (e.g., sustained sobriety) for this client population, with a recent follow-up assessment demonstrating that only fourteen of 81 clients had remained sober at six months after treatment discharge. It is crucial to note, however, that such disheartening outcomes are not at all unique to Lodge programs; residential treatment for AIs throughout the region—most of which are not tailored for an AI clientele—are regularly observed to result in similarly discouraging relapse rates.

In stark contrast to standard residential treatment, several Lodge staff members attribute their own stable abstinence to regular engagement in local "traditional" cultural activities, especially participation in indigenous ceremonies such as sweat lodges, sun dances, and pipe rites. Indeed, since the Red Power movement of the 1970s, intense tribal commitments to cultural preservation and revitalization have been evident throughout Native America, reversing the longstanding historical trend of Euro-American suppression of AI cultural practices (especially religious traditions). Such commitments find continued expression by recent generational cohorts of AIs who, when it comes to matters of recovery, healing, and wellness in the context of SUDs, now routinely assert that "our culture is our treatment." So prevalent is this claim throughout Indian country, and so readily has it been embraced and promoted by the professionals who work there, that some investigators have felt compelled to remind the field that the "culture as treatment" (CaT) assertion remains an open empirical question (Brady 1995). And yet, empirical investigations of the CaT hypothesis—namely, that a (post)colonial return to indigenous cultural orientations and practices is sufficient for effecting abstinence and recovery from SUDs for many AI individuals—have yet to appear in the scientific literature (Gone 2011a).

The first author, a university-based research psychologist, approached the second author, the Lodge Director, in the spring of 2008 with the idea for this collaboration. The rationale for partnering with Lodge staff was fourfold: (a) the authors were previously acquainted from prior consultation on similar issues, (b) the Director maintained an unrivaled record and reputation for longstanding, effective leadership at the Lodge within an administratively challenging reservation setting, (c) the Blackfeet Nation shares a great deal of culture and history with the nearby Gros Ventre Nation, where as a tribal member the first author has conducted prior research, and (d) tribally controlled SUDs treatment programs—typically funded by the federal Indian Health Service but administered by tribal governments—represent especially compelling partners for treatment innovations because they are less constrained by the institutional regimens governing health services administration. The result was the establishment of a research partnership that has now existed for three years. Beyond two initial visits in 2008 devoted to formulation of this project, the second stage of the collaboration involved the securing of intramural seed funds from the University of Michigan that allowed Gone to reside on-site during August of 2009 for more extended consultation.

It is important to note that this collaborative endeavor remains grounded in a relational ethics (Fisher 2006). Adoption of this alternative ethical paradigm is important because AI communities have routinely been "subjects" of research designed by and for non-AI outsiders that excluded AIs from meaningful engagement with the design, interpretation, and circulation of research findings. As a consequence, many AIs have expressed alienation and anger toward exploitative research relations that, in effect, represent (and sometimes even reproduce) the injuries of colonialism (such as punitive surveillance and reinforcement of ugly ethnoracial stereotypes). Thus, attention to research process involving substantive collaborations or partnerships with AI communities is quickly becoming the norm (e.g., Mohatt et al. 2004). These commitments shaped the inquiry undertaken in August of 2009. The goal of this "before the beginning" consultation was to map out important preliminary details of the project relative to the design of a locally desired cultural intervention. Although such planning might seem straightforward, there were in fact basic decisions requiring thoughtful deliberation that required face-to-face interaction within the community (e.g., how to address religious pluralism in the community when spirituality was recognized as centrally important to AI recovery from SUDs).

In an early presentation to Lodge staff, the first author invited open consideration of a radically alternative, locally emergent cultural approach to substance abuse treatment. Sustained consultation with the Director and his full-time Cultural Counselor resulted in the conceptualization of a seasonal (summer) cultural immersion camp that would afford residential clients the opportunity to approximate the day-to-day experiences of their pre-reservation ancestors. The establishment of an advisory group—comprised of Blackfeet sacred bundle keepers and leaders of the Crazy

Dogs ceremonial society (a group of Blackfeet dedicated to revitalizing traditional religious practices)—was envisioned as key not only to the initial conceptualization of an appropriate intervention but also to future implementation and evaluation. Inspired by the survival camps of the Red Power movement, this local intervention was proposed for implementation during the summer months in multiple four-week cycles. Specifically, the camp would consist of clients and staff residing in gender-segregated tepees pitched well away from settled areas of the reservation for the duration of the treatment cycle. Camp life would involve "living off the land" while participating in a variety of associated Blackfeet traditional activities.

Such activities would include: food procurement through hunting, trapping, fishing, and gathering of roots and berries; food preparation through butchering, storing, preparing and cooking; camp maintenance such as pitching tepees, hauling water, and gathering firewood; equestrian skills such as horse care, training, and riding; cultural instruction concerning traditional language, kinship, and life ways; traditional crafts such as leatherwork, carving, beading, and quillwork; ceremonial orientation, including rudimentary instruction in Blackfeet cosmology, oral tradition, and basic ritual protocol; and ceremonial participation through observance of the daily sweet grass ritual and attendance at bundle openings and the Okan (the principal Blackfeet ceremony centered on the sun). Moreover, one important "through line" of camp activity—for those who so choose—would be the seminal opportunity to craft an individual pipe for personal prayer under careful ritual mentorship. Fidelity across camp offerings would be monitored with an eye toward standardization in terms of camp duration, continuity of staffing, kind and number of activities, and structure of staff-client interactions. The obvious priority in this project was to pilot and assess outcomes for a promising local intervention as envisioned by the community partners, but clearly this vision is ideally suited to an empirical exploration of the CaT hypothesis as well.

IMPLEMENTATION AND EVALUATION OF THE CULTURALLY-LOCAL INTERVENTION

The formulation of an indigenous cultural immersion program by project partners is obviously just the first step in establishing a radically alternative, locally emergent cultural approach to substance abuse treatment and in assessing the CaT hypothesis empirically. Subsequent implementation and evaluation of the proposed seasonal cultural immersion camp is necessary if this sort of culturally grounded alternative is ever to achieve the status of an evidence-based intervention for AI SUDs. In the fall of 2009, an ambitious proposal for funding was submitted to the National Institutes of Health to put forward these important next steps. The proposal was not favorably evaluated (which was not especially surprising given the conservative nature of competitive health research funding evaluations), and other professional commitments have temporarily delayed submission elsewhere or in another form. Nevertheless, the project partners remain committed to ongoing pursuit of funding for implementation and evaluation. In terms of research strategy, the proposal described a mixed-method approach, involving a quasi-experimental comparison group design as contextualized by anthropological ethnography, to assess treatment outcomes for a sample of Lodge clients who would volunteer for participation in the study. The reality of undertaking a small-scale, community-based intervention trial imposes definite limits on the ability to rigorously assess outcomes—thus, the ethnographic component was intended to capture the intervention process from multiple perspectives as a valuable contribution in its own right.

The hypotheses for this investigation were: (1) clients participating in the immersion camp will complete treatment at higher rates than clients participating in standard Lodge residential treatment; (2) clients participating in the immersion camp will achieve reduced substance use (i.e., fewer average drinks per drinking day), reduced relapse rates (i.e., higher percent days abstinent), and more remitted SUD diagnoses over a year-long follow-up compared to clients participating in standard treatment; (3) clients participating in the immersion camp will report more favorable evaluations of the intervention setting than clients participating in standard treatment; and (4) clients participating in the immersion camp will find novel and deeply meaningful sources of strength and satisfaction in service to long-term recovery through the cultural traditions and practices they learn. The first three hypotheses were to be examined through established measures of outcome, while the final hypothesis was to be explored ethnographically. In sum, the evaluation of study hypotheses would require an analysis of treatment completion rates, improved longitudinal outcomes, comparative client evaluations, and ethnographic interpretations based on participant-observation, focus group interviews, and individual interviews to afford insights into the emergent meanings of CaT for AI participants.

Again, the proposed assessment of the camp alternative represents a pioneering empirical exploration of a widely circulated claim throughout indigenous communities concerning the presumed therapeutic benefit of (post)colonial cultural reclamation (Gone 2011a). But whether in this particular form or any other that is collaboratively developed in close partnership with an AI community, what rationale might be offered for why such radically innovative cultural alternatives might be expected to produce better outcomes than treatment-as-usual for AIs with SUDs? Four strands of rationale are offered for why this previously unexplored claim—the CaT hypothesis—remains a scientifically plausible proposition worthy of empirical investigation.

First, it is increasingly common throughout Indian country for researchers, clinicians, and tribal members alike to attribute epidemic levels of SUDs in AI communities to "historical trauma" (Brave Heart 2003; Gone 2009). Briefly, historical trauma indexes the intergenerational reverberations within AI communities of the historical violence and violation associated with Euro-American colonization. The discourse of historical trauma locates the source of AI pathologies—and especially SUDs—in this history of colonization and prescribes a communal return to AI religion, language, and culture as restorative and therapeutic. The promise of AI culture is thus seen to depend fundamentally on reversing the processes of anomie, alienation, self-hatred, and imposed assimilation wrought by the colonial encounter. Importantly, it does so not merely for individuals but for collectivities of AIs who embrace an ethos of interdependence. Thus, the discourse of historical trauma reframes "personal problems" such as SUDs as communal challenges that are most effectively overcome not by interventions targeting the individual but by interventions targeting the collective. The seasonal cultural immersion camp is an exemplar of this latter form of intervention because culture and its constituent practices are by definition socially shared.

Second, the CaT hypothesis is grounded in the life experience of many AIs who have recovered from SUDs. In this regard, Torres Stone and colleagues (2006) determined that, for 732 AIs from reservations throughout the upper Midwest, alcohol cessation was significantly predicted by "traditional spirituality" and "participation in traditional activities" in their logistic regression analysis. Spicer (2001) interviewed 48 self-identified "problem drinkers" who expressly situated their recovery in processes of "cultural restoration of the self." Similar processes were central in the life narratives of staff and clients obtained during the first author's study of the Manitoba AI community treatment program as well (Gone 2009; 2011b). Most significantly, this metaphorical return to the "Red Road"—indexing newfound participation in traditional activities and practices—was also observed to be important for the Blackfeet partners. For example, at a gathering of the Crazy Dogs society during the August 2009 consultation efforts, many members of the society were astonished to hear that the therapeutic benefits of traditional practices were in question. One society leader reacted with visible incredulity: "Every one of us sitting in this circle is testimony to the healing power of these [traditions] for recovery."

Third, beyond post-hoc attributions of the importance of traditional activities and practices for achieving sobriety, AIs routinely offer plausible explanations for the efficacy of CaT. These include spiritual revitalizations that result from indigenous ceremonial participation, interpersonal reorientations that yield new and renewed relationships in support of sobriety, and psychological transformations that alter personal identity, motivation, and purpose in service to positive lifestyle change. To the degree that a return to AI tradition might reorganize the spiritual/existential, relational, and intrapersonal domains for AI clients, recovery from SUDs seems a plausible outcome. It is particularly important to note that one distinctive feature of the proposed cultural immersion camp is socialization into a local, vibrant, and abstinent social network based neither on SUDs nor recovery per se—a pathology-based discourse that some AIs resent—but instead on Blackfeet cultural reclamation and revitalization. As a result, client involvement in this network—involvement that is incompatible with substance use—is expected to carry forward well beyond the intervention proper.

Finally, the innovative cultural alternative proposed here may facilitate AI client recovery in a manner that promotes rather than disrupts collective AI "nation building" and self-determination. Specifically, in the midst of client struggles with SUDs—with all of the attending chaos, anomie, alienation, and despair that afflict this subset of community members—the seasonal cultural immersion camp promises to engage potential AI clients in a program of overt tribal "traditionalization." If successful, the result would be not just personal sobriety, but also enlistment in a communal effort to rebuild AI society in ways that simultaneously draw continuity with the pre-reservation past even as they chart self-determined paths into the future. That is, CaT holds the promise of achieving AI recovery from SUDs by actively supporting—rather than supplanting—AI cultural legitimacy. As a result, a primary innovation associated with this distinctive cultural alternative involves the unprecedented potential for simultaneous reduction in AI SUDs at the individual level *and* promotion of AI community resurgence at the collective level.

FUTURE DIRECTIONS

Whether with this project or another similar intervention development project elsewhere in Indian country, the opportunity to test the CaT hypothesis is significant. Specifically, the inherently conservative nature of scientific inquiry has ensured that "culture" is most likely to appear as a secondary consideration within studies of SUDs treatment among AIs relative to incorporation of evidence-based practices that have already been established as efficacious with non-AI samples. This conservative approach to evaluating interventions in Indian country has ensured that exogamous treatments—usually proffered with locally salient cultural packaging—have received scientific attention while truly indigenous alternatives have not (Gone 2011a). And yet, the challenge of what has been termed cultural competence extends well beyond the superficial packaging of behavioral health treatments to the more fundamental assumptions undergirding psychosocial intervention relative to implicit culturally

prescribed modes of selfhood, personhood, emotional experience and expression, and the like (Wendt & Gone in press). Moreover, it is important to recognize that scientific evaluation of therapeutic approaches is not randomly distributed across therapeutic modalities. Instead, there is a (nonsurprising) consolidation of research funding, peer-reviewed publication, outcome evidence, and scientific legitimacy surrounding certain approaches to behavioral health treatment. The result is that AI interests, knowledges, and practices have not been afforded a key opportunity for authoritative recognition within the health sciences. Thus, the evaluation of locally emergent, culturally grounded treatment alternatives retains not only the possibility for achieving greater reservation treatment effectiveness but also the prospect for promoting social justice relative to the potential legitimation of a wider diversity of health interventions.

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