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Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment

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Abstract

Indigenous “First Nations” communities have consistently associated their disproportionate rates of psychiatric distress with historical experiences of European colonization. This emphasis on the socio-psychological legacy of colonization within tribal communities has occasioned increasingly widespread consideration of what has been termed *historical trauma* within First Nations contexts. In contrast to personal experiences of a traumatic nature, the concept of historical trauma calls attention to the complex, collective, cumulative, and intergenerational psychosocial impacts that resulted from the depredations of past colonial subjugation. One oft-cited exemplar of this subjugation—particularly in Canada—is the Indian residential school. Such schools were overtly designed to “kill the Indian and save the man.” This was institutionally achieved by sequestering First Nations children from family and community while forbidding participation in Native cultural practices in order to assimilate them into the lower strata of mainstream society. The case of a residential school “survivor” from an indigenous community treatment program on a Manitoba First Nations reserve is presented to illustrate the significance of participation in traditional cultural practices for therapeutic recovery from historical trauma. An indigenous rationale for the postulated efficacy of “culture as treatment” is explored with attention to plausible therapeutic mechanisms that might account for such recovery. To the degree that a return to indigenous tradition might benefit distressed First Nations clients, redressing the socio-psychological ravages of colonization in this manner seems a promising approach worthy of further research investigation.

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Native American chemical dependency is caused by post-traumatic stress syndrome. I agree with that. So you have to treat that . . . Are there programs for treating Native Americans for that? They just started. Because somebody said *all* Native Americans are [suffering from] post-traumatic stress. I agree. So I know that we have to provide some kind of a service, utilizing again our culture to deal with [this] post-traumatic [stress] . . . The programs we have [now] are Western cultural programs. We're just beginning to develop our [traditional] ways and means, [those] used in our cultural/spiritual ways. We're just starting. And they're working.

Marvin, Gros Ventre spiritual leader

Native Americans or “First Nations” peoples are the contemporary descendants of the indigenous peoples of North America. The United States currently recognizes about two million individuals who are enrolled citizens of 565 federally designated tribal nations (U.S. Bureau of Indian Affairs, 2011). Canada is home to roughly 1.2 million individuals who endorsed Aboriginal identity in the 2006 Canadian census, including about 50,000 Inuit and about 625,000 “status Indians” as defined by the Indian Act (Statistics Canada, 2008). These communities still contend with the devastating legacy of Euro-American and Euro-Canadian settler colonialism. Results of this legacy include entrenched poverty, invidious discrimination, and associated distress. Such distress includes a range of formally designated “mental health” problems, such as substance dependence, pathological affect, and suicide (Huang et al., 2006; Olson & Wahab, 2006). Thus, there can be little doubt that indigenous peoples in both countries—especially those in impoverished reservation or urban settings—suffer from an alarmingly high degree of psychosocial disruption and disorder (Gone & Trimble, 2012; Kirmayer, Brass, & Tait, 2000).

Mental health researchers and professionals, as well as First Nations community members, have consistently associated these disproportionate rates of pathological distress with indigenous historical experiences of colonization (E. Duran & Duran, 1995; Gone, 2007; Kirmayer, Simpson, & Cargo, 2003). Indeed, professional and community discourse regarding mental health in Native North America is in many ways distinguished by this emphasis on the impact of colonization and attending historical consciousness in tribal communities (Jervis et al., 2006). For example, the words that open this article were offered by an elderly spiritual leader from the author's home reservation in Montana (Gone, 2006). They reflect the now commonplace associations that are made between prevalent First Nations community problems (e.g., “chemical dependency”), the psychosocial impact of the colonial legacy (i.e., collective “post-traumatic stress”), and the emergence of local

treatment approaches (i.e., “our cultural/spiritual ways”) as a principal remedy for these mental health concerns. The convergence of these features is routinely indexed in the currently widespread indigenous concept of *historical trauma*.

In this article, I explore the discourse of historical trauma as it has been adopted and promoted in First Nations settings, with an eye toward the implications of this potent discourse for the designation of treatment mechanisms that might facilitate recovery and well-being for First Nations communities. First, I will review the deleterious impact of traumatic experience on First Nations peoples and trace the origins and significance of the concept of historical trauma. Then, I will present a case illustration of historical trauma and its purported remedy drawn from a Manitoba First Nations treatment program. Finally, I will offer a plausible rationale for considering newly reclaimed indigenous cultural participation as an important therapeutic mechanism for redressing rampant mental health problems in Native North America.

Traumatic experience in First Nations community contexts

Prior to consideration of *historical trauma* in First Nations communities, it is important to first appreciate the degree of violence, abuse, and other forms of *directly experienced* traumatic stressors that First Nations peoples encounter all too routinely.

From trauma to PTSD

Trauma and its pathological sequelae appear to feature prominently in the lives of contemporary First Nations community members, particularly during the formative years of development. For example, three quarters of American Indian women seeking primary care medical services endorsed experiences of childhood abuse or neglect, with 40% reporting severe child maltreatment; severely adverse childhood experiences were associated with lifetime alcohol dependence and posttraumatic stress disorder (PTSD; B. Duran et al., 2004). A genetic linkage study of a large sample of southwestern Native Americans representing three interrelated family pedigrees revealed that 49% of women and 14% of men were sexually abused as children, greatly increasing their risk for psychiatric problems (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997b). Gay, lesbian, and bisexual (or “two spirit”) Native Americans were even more likely than their heterosexual counterparts to report childhood abuse (Balsam, Huang, Fieland, Simoni, & Walters, 2004). A school-based sample of Native children also reported high rates of exposure to potentially traumatic events, with 61% experiencing at least one such event and two thirds of these endorsing two or more such events (Jones, Dauphinais, Sack, & Somervell, 1997). Other studies have reinforced the link between adverse childhood exposures, including potentially severe traumatic events, and alcohol dependence for First Nations people (Boyd-Ball, Manson, Noonan, & Beals, 2006; Koss et al., 2003).

In general, overall rates of traumatic exposure from *any* source are high, leading to elevated rates of PTSD. Statistics recorded by the U.S. Department of Justice revealed that American Indians on average have encountered violence more than twice as often as other Americans (Perry, 2004). Furthermore, according to Amnesty International (2007), more than one third of indigenous women in the U.S. have experienced sexual assault. During the war in Vietnam, Native American men were more likely to serve in the military, more likely to experience combat, and more likely to suffer from PTSD as a consequence than any other ethnoracial group in the United States (Beals et al., 2002). In a non-convenience subsample from the above-mentioned southwestern Native family pedigree study, 81% of these respondents endorsed first-hand experience of some traumatic event, with almost 22% of the subsample meeting criteria for lifetime PTSD (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997a). In the most rigorous instance of psychiatric epidemiology ever undertaken in Native North America, two thirds of American Indians from two reservation populations—at nearly equivalent rates for both men and women—endorsed at least one of 16 types of potentially traumatic experience (Manson, Beals, Klein, Croy, & the AI-SUPERPFP Team, 2005). Not surprisingly, elevated rates of both lifetime alcohol dependence and PTSD were found for these two large tribal groups (Beals, Manson, et al., 2005; Beals, Novins, et al., 2005).

In sum, psychiatric investigations among Native Americans have demonstrated disproportionately high rates of exposure to traumatic experiences in the context of poverty, violence, and substance abuse, leading in some instances to more than double the prevalence for PTSD in comparison to the general U.S. adult population (Kessler et al., 2005).

From PTSD to historical trauma

In light of such commonplace exposure to potentially traumatizing events, one might anticipate a concerted professional effort in First Nations communities organized around the prevention and treatment of PTSD. Although mental health professionals working in these settings certainly address this disorder in their clinical practice, it remains somewhat striking that the principal discourse about post-traumatic pathology that circulates in these communities is *not* in fact centered on PTSD proper but rather on historical trauma (HT). The concept of HT originally emerged from the psychoanalytic literature, especially as it pertained to Holocaust survivors and their descendants. It was first applied to the indigenous peoples of the Americas in the early 1990s by Maria Yellow Horse Brave Heart, a Lakota social work researcher whose training included psychoanalytic psychotherapy (Brave Heart-Jordan & DeBruyn, 1995; see also Brave Heart, 1998, 1999a, 1999b, 2003). In tandem with this work, Eduardo and Bonnie Duran (1995; see also E. Duran, 2006; E. Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998) likewise promoted a virtually identical concept under the label of *soul wound* (and HT was simultaneously referenced in an Alaska Native health care context

as well [Terry, 1995]). In a recent overview of HT among American Indians and Alaska Natives, Evans-Campbell (2008) defined the concept as

a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events. (p. 320)

From this definition, the features that conceptually distinguish HT from PTSD begin to emerge (Evans-Campbell, 2008; Palacios & Portillo, 2009; Sotero, 2006; Walters et al., 2011). First, HT is described as more *complex* in its antecedents, evolution, and outcome than the relatively straightforward cause, course, and consequences of PTSD. For example, the duration and impact of potentially traumatizing colonial injuries may well imply a broader range of dysfunctional reactions—including indigenous anomie, demoralization, substance abuse, and suicide (Gone, 2007)—that extend far beyond the recognized symptoms of PTSD proper. Second, HT is described as a *collective* phenomenon shared by members of an identifiable group who have experienced deliberate conquest, colonization, or genocide, whereas PTSD remains a disorder of the individual. For example, the members of any given Native community may have together grappled with particular expressions of colonial subjugation, including military conquest, epidemic disease, forced relocation, reservation captivity, religious suppression, resource theft, environmental degradation, family disruption, government dependency, and coercive assimilation. Thus, HT is described as incorporating *both* the psychological and social sequelae of historical oppression whereas PTSD—as a form of *psychopathology* that is officially classified as a *mental* disorder so that it can be treated by *mental* health professionals—is largely confined to the psychology (and accompanying biological substrates) of the individual.

Third, HT is described as *cumulative* in its impacts over time such that multiple traumatic experiences are said to exhibit additive effects resulting in proportionately greater distress and disability in comparison to the sequelae of more limited traumatic exposures. So, an indigenous group subjected first to military violence, then to reservation captivity, then to systematic cultural repression, then to near starvation would be expected to contend with compounded levels of distress relative to tribal groups that had similar historical experiences without, say, military confrontations. Finally, HT is described as *intergenerational* in its impact in comparison to the disruptions of PTSD that principally affect a single life for a circumscribed period of time. Indeed, this intergenerational quality is what most distinguishes HT from PTSD (even from so-called *complex* PTSD [Herman, 1997]). The claim here is that offspring or descendants of individuals who have experienced HT are themselves more susceptible to pathological dysfunction as a consequence of the traumatic experiences of their ancestors (and at least partly independent of their own traumatic experiences). For example, the murder of a great grandparent by the U.S. Army in the 19th century is claimed to predispose

the living descendant today to greater susceptibility to dysfunctional responses in the context of current stressors than PTSD proper would predict or explain. Proponents of HT are usually vague about the mechanisms for this “secondary transmission” of psychological trauma, but postulated processes recently include parental communication (Palacios & Portillo, 2009) and unspecified epigenetic mechanisms (Walters et al., 2011).

Socializing trauma and its treatment

As an “interactive” human kind (in philosopher Ian Hacking’s [1999] sense of this concept), HT thus appears to have entered the American Indian mental health lexicon through three simultaneous publications in 1995 (Brave Heart-Jordan & DeBruyn, 1995; E. Duran & Duran, 1995; Terry, 1995). The purpose for introducing this new category of person within indigenous community contexts was at least fourfold. First, it seemed self-evident to these mental health experts that the established category of PTSD was not sufficient for reflecting the complexity of Native distress surrounding trauma, which almost never results in circumscribed instances of PTSD but rather remains associated with a host of additional problems such as substance abuse. Thus, HT was theorized as a more comprehensive explanatory construct. Second, as a counterbalance to the increasing prevalence of biological explanations for mental health problems, HT accentuates and implicates the processes of colonization rather than faulty genes or broken brains as fundamentally causal in the origins of epidemic levels of distress that afflict too many First Nations communities. Thus, HT was theorized as a sociopsychological explanatory construct.

Third, in preserving a relational rather than an individual emphasis on Native life, HT links community members together in shared struggles to overcome bitter circumstance or frightful ordeal in the wake of colonization. Thus, HT was theorized as an explanatory construct based on descent group. Finally, in support of widespread efforts toward indigenous cultural reclamation or revitalization, proponents of HT explicitly identify and celebrate the potential of “traditional” approaches and interventions—often but not always as adjunctive to conventional clinical practices—as an important means for arresting the cumulative, intergenerational impacts of HT. Thus, HT was theorized as a countercolonial explanatory construct. Irrespective of the claims of HT proponents more generally, this final purpose is most relevant for consideration of possible treatment mechanisms for indigenous pathological traumatic reactions. Specifically, local First Nations responses to instances of HT typically include a *bricolage* of treatment approaches that almost always includes opportunities for indigenous cultural education and ceremonial participation in service to powerful renewals in tribal identification.

In the remainder of this article, I will focus on one particular instance of a First Nations community-based treatment program addressed to an exemplary form of HT so as to illuminate the promise of *culture-as-treatment* in indigenous settings (Brady, 1995).

A case illustration of historical trauma

Situating the case

The case material presented in this article was obtained as part of a larger study about “models and metaphors” of Aboriginal healing, approved by the University of Michigan Institutional Review Board (Gone, 2008, 2009, 2011b). As part of this study, in late 2003, I commenced 7 weeks of participant-observation in a nationally accredited, tribally administered substance abuse treatment center on a northern Algonquian Manitoba reserve. The focus of my inquiry was the outpatient treatment program within this “Healing Lodge,” staffed by four tribal members and funded by the national Aboriginal Healing Foundation (AHF) in Canada. The AHF was created by Canada’s parliament in the wake of the Royal Commission on Aboriginal Peoples during the 1990s to help redress the deleterious impacts of the Canadian residential schools. These schools were created as deliberate agents of cultural assimilation for generations of Aboriginal pupils, whose attendance was mandated by the federal government. The philosophy of these schools was explicitly assimilative: administrators and teachers overtly sought to “kill the Indian and save the man” (Adams, 1995). As a consequence, in Canada—where military confrontation was much less prevalent than in the United States—“survival” of these sometimes brutal residential schools remains the most proximal instance of having contended with Euro-Canadian colonization. As of 2006, the AHF indicated that some 86,000 “survivors” of the residential school system were then still living, while an additional 287,350 Aboriginal persons were estimated to have experienced the “intergenerational impacts” of these institutions. The adverse psychosocial correlates of indigenous matriculation to residential and boarding schools have been documented across several studies in both Canada and the United States (Boyce & Boyce, 1983; Corrado & Cohen, 2003; Dinges & Duong-Tran, 1994; Dlugokinski & Kramer, 1974; Irwin & Roll, 1995; Krush, Bjork, Sindell, & Nelle, 1966; Million, 2000), but it is in Canada where such attention has rendered the residential school experience a principal exemplar of HT for First Nations peoples (Assembly of First Nations, 1994; Bull, 1991; Miller, 1996; Milloy, 1999).

In response, the mandate of the AHF was to disburse hundreds of millions of dollars to Aboriginal communities for support of local healing initiatives that would counteract the intergenerational legacy of abuse in the residential schools. Of the targeted population, the scores of projects and programs funded by the AHF were believed to have reached perhaps 55% of these individuals with community-controlled healing resources. In the AHF report’s (2006) “framework for understanding trauma and healing related to residential school abuse,” three “necessary elements” for promising healing practices were listed (p. 113): Aboriginal values and worldviews, personal and cultural safety, and the capacity to heal. In addition, three “pillars of healing” were explicitly derived from the

activities of funded projects: reclaiming history, cultural interventions, and therapeutic healing. Obviously, then, Aboriginal worldviews and cultural interventions featured prominently in local efforts to contend with this particular legacy of HT. Indeed, the Healing Lodge that served as my site of inquiry had recently adopted vision and mission statements that identified the Aboriginal symbol of the medicine wheel as a potent treatment philosophy, employed many staff who were themselves engaged in cultural revitalization activities and traditional ceremonial practices, and institutionalized specific cultural activities such as sweat lodge rituals or talking circles for clients on a routine basis. The overt goal of this traditional cultural integration was to facilitate the “cultural renaissance of the Red Man” and to promote robust Aboriginal cultural identification as a remedy to anomie and its associated ills, such as violence, family dysfunction, and substance dependence (Gone, 2008, 2011b).

Presenting the case

The recounting of residential school experiences by Aboriginal survivors has taken on a recognizable form in the wake of an indigenous social justice movement and Canadian national efforts toward redress and reparations (Darnell, 2006; Million, 2000). Indeed, there might now be said to be a residential school narrative *genre*, multiple examples of which I heard during my 2003 fieldwork in Manitoba. One interview I conducted with a former client of the Healing Lodge exemplified this narrative form. Diane (a pseudonym) was a northern Algonquian First Nations woman, in her mid-50s at the time, who had married too soon after residential school and subsequently divorced while still rearing her five children (cf. Gone, 2008). As an adolescent, she attended residential school in Manitoba for five years during the 1960s. She recounted a variety of psychosocial problems during her adult life that she attributed to her experiences in residential school. Rather than the recognizable symptoms of PTSD (pertaining to re-experience, avoidance, or physiological arousal), Diane’s problems were primarily framed in interpersonal, spiritual, and cultural terms. Ultimately, she testified to the power of an indigenous traditional treatment approach that she encountered at the Healing Lodge for inaugurating her remarkable personal transformation rather recently in her adult life.

Trauma. Early in her narrative account, Diane recalled her initial excitement as she settled in to the regiments of residential school life, which quickly turned to loneliness, alienation, and anger.

I remember my number was 52 I was numbered Everything we were doing—clap, clap, clap—they all lined up. Line up to go to bed, and line up to go to school, and line up to go to church, and line up to go for meals. We were always in line. Going on like that for five years. The first year was the hardest.

One facet of school life that made adjustment so difficult was the pronounced intertribal tensions between groups of students that were exacerbated by limited facility with English. Specifically, students related to one another through their ability to communicate verbally despite rules that strictly forbade conversing in Aboriginal languages. As a consequence, violence between students was not uncommon.

And yet, violations of school rules—including the English-only mandate—carried harsh penalties.

Sometimes when you have to be punished, they shut me in the dark room. They used to give you water and bread for two days.... In order to go to the washroom [you] start hollering.... You know what I did? Well, they didn't hear me knocking, knocking.... So there was the punishment [for not making it to the bathroom, too].

Corporal discipline was common as well.

I was always in fear.... We had a teacher that was... very abusive when we did something wrong... If we speak [our Native language], we would be physically punished.... Because this priest, the form of discipline he used to give us was physical discipline. Used to get strapped.... It's so hurtful. And they still expect us to go to the classroom and learn. And you can't learn. I was in so much pain.

As a result, Diane ran away. She was found and returned to the school, where her head was shaved and she was publicly “displayed” as a warning to other students of the consequences of flight.

As “total institutions,” the residential schools were not infrequently the sites of truly monstrous violations perpetrated against Aboriginal students. Like many residential school survivors, Diane was sexually assaulted by a member of the school's staff. She reported this crime to one of the teachers.

[This nun] says, “Oh you can't say that [about] this priest, he's a man of the cloth! You'll go to the chapel and say your ten Hail Mary's to be forgiven.” It wasn't me that [needed to ask] for forgiveness, it was that priest who did something to me that later on in my adult life would affect me.

The message imparted through such interactions was unambiguous.

Why should I tell somebody that didn't believe me what was going on? “It's not nice for you to speak like that!” It wasn't even nice to express your feelings. It wasn't nice for you to cry. If you cry you'd be punished.

Suppression of emotion and self-expression in the lives of Aboriginal students was a predictable outcome of such circumstances.

[There was] nowhere to run to. No one to talk to. No one cared for us. That's how I see that residential school. . . . And they provide you shelter, clothing, food, but they never like to hear how you feel. There was no love.

Once emancipated from her institutional confinement, Diane emerged into early adulthood without any "sense of belonging" to her tribal community and minimal prospects for making a life in a wider, Whiter world that discriminated against Indians.

As a result, the lessons of residential school would chronically trouble Diane throughout her adult years. She characterized these problems as common to former students of these schools.

Our low self-esteem. Go down [to its root cause], and it's fear and anger. And all that emotional hurt. . . . Basically, you want to punch someone! You began to be a violent person because you're so angry about all that abuse you went through. Emotional abuse, physical abuse, sexual abuse, psychological abuse, even spiritual abuse. [The latter] meaning that they didn't want me to practice my own culture and spiritual practices.

These psychological and spiritual problems led to pronounced difficulties in social relations as well.

I'm divorced. I've had numerous unstable relationships. I didn't have parenting skills. . . . I know that's sad for us residential school survivors. . . . They get married, divorced, single parent, married, divorced. It's a cycle. . . . we're living. . . . A cycle of abuse. Got married. Became an alcoholic. Divorced. Remarried.

For many former students, their alienation from Aboriginal cultural practices is a particularly bitter pill to swallow.

I lost my culture. . . . I didn't know [about] the sweat [lodge ceremony]. I didn't know the meaning of the sweat [lodge]. I didn't know the meaning of the symbolics of our culture. Instead I know the symbolics of the Catholic faith.

Thus, the legacy of the residential schools for these survivors involves shared disruptions in the psychological, social, and spiritual realms of experience that the concept of HT was intentionally designed to capture and represent.

Recovery. Fortunately for Diane, her narrative did not end there. Around the age of 40, she began to pull her life together. She pursued a university education, sought treatment for her drinking, and began what she referred to as her "healing journey." Although she first obtained support for combating her substance abuse through non-Aboriginal programs, she credited the Healing Lodge with ultimately enabling her recovery.

So when they started this [Healing Lodge] here, that's where I learned everything. I thought it was only just to maintain your sobriety. That was good enough for me 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. And you've got to look at yourself emotionally, mentally, physically, and spiritually in order to have that balance of living This is where I learned my culture, too. And this is where I started healing.

This reference to self-examination for achieving balance across four domains of human experience—the emotional, mental, physical, and spiritual—clearly invokes the medicine wheel philosophy of treatment at the Healing Lodge.

Diane emphasized this connection between Aboriginal practices and well-being in her healing narrative.

This is where I start my healing journey. And this is where I practice my Native culture. I go to sweats. I go to fastings. I go to powwows and participate. It's a good feeling when you're starting to find your identity. To have that sense of belonging. To have that empowerment. And to have that identity in the purpose of (your) life. It makes me feel good.

Thus, it was in the context of discussing the cultural aspects of her healing journey that Diane first referenced the issue of identity and a recapturing of the *sense of belonging* that was an intended casualty of the residential school. Equipped with newfound empowerment, purpose, and well-being that arose from this Aboriginal cultural identification, Diane explained how her outlook and interactions had been transformed as a result.

I'm proud to be a Native now. I'm proud for who I am. I know my identity. I don't care if anybody calls me a dirty Indian, lazy Indian Well, so what? I'm still a human being Whereas a long time ago I would punch somebody [who] would ever call me that But today I'm very proud for who I am But a long time ago I was too angry. Resentful So those were all the defects of characteristics I had before I started on my healing journey.

Indeed, when I last spoke with Diane, she had long since put alcohol away and was back at university pursuing formal credentials in counseling so that she might facilitate the healing of other Aboriginal people from the legacies of colonization.

One consequence of Diane's recovery was a novel awareness of the intergenerational impacts of residential school experiences on First Nations families. When I inquired late in the interview what the term "residential school syndrome" might mean to her, she replied with reference to her own grandmother.

I remember that my granny, [during World War One], she attended residential school. And I was wondering why she used to be so angry Then I asked her one day. She

said she was in a residential school. And that . . . school burned down. And I think two of her sisters died in that [fire]. And she used to talk about it, and she used to cry. And she said, "I know how it is when you go to residential school." My grandmother had that residential [school] syndrome . . . She was there. And she told me she was an abused woman in residential [school]. All forms of abuse, too.

Interestingly, the similarities in the school experiences of Diane and her grandmother led Diane to reflect even more on the significance of her own therapeutic program.

I remember that she never disclosed [her abuse] until she was 70 years old . . . She started telling me that, and I was telling her, "Oh, granny, I'm doing this [recovery program for that] . . . Learning how many of us went to the residential school. What impact it has had on us . . . That my children had that impact on [them] because of the way [I used to] discipline. It is a learned behavior, they say. And it isn't normal." I remember [talking with her about this].

Thus, in the context of this remarkable discussion with her own grandmother, Diane further traced the impact of residential schooling experiences on her own children, whom she elsewhere acknowledged as having had a difficult time offering her forgiveness for the manner in which she had disciplined them during their developing years.

Appraising the case

Diane's account exemplifies one prominent form of experience that has been classed as indigenous HT, namely the life course of the residential school survivor. In her narrative, she conveyed the homesickness and estrangement she felt on arrival to this conflict-ridden multi-tribal setting, where students were forbidden to speak their indigenous languages in service to Euro-Canadian assimilation. Any enduring lessons of formal classroom instruction were displaced from her account by memories of Christian religious indoctrination, dehumanizing discipline, and criminal assault by the school's highest authority figure. Interestingly, communicative challenges featured centrally in Diane's interview, from the difficulties of mastering proficiency in English and orienting to a confusing multilingual peer environment to the institutional suppression of emotional expression and prejudiced dismissal of her first-hand allegations of sexual violation. Diane explicitly linked these formative experiences to enduring problems throughout her adult years, including alcoholism, criminal behavior, religious alienation, and chronically troubled family and romantic relationships. Indeed, the legacy of these early communicative disruptions seemed to pervade the interview itself as Diane evidenced an unusual and erratic form of spoken English. Of course, these sorts of traumatizing first-hand experiences are usually assumed to find ready accommodation within the established rubric of PTSD. What PTSD typically fails to capture is the

complex, collective, cumulative, and intergenerational qualities of Diane's residential school experience.

Prototypical traumatic stressors associated with PTSD are frequently described as singular catastrophic events such as a one-time natural disaster or sexual assault. The more that a variety of traumatic experiences recur over time so as to blur together, such as in the context of ongoing warfare or totalitarian rule, the more difficult it becomes to attribute symptoms of PTSD to the required index traumas. Diane's residential school experience illustrates this complexity of traumatic experience in which her five-year stint at this institution included the fusion of a variety of troubling occurrences, ranging from interpersonal alienation to sexual victimization. It is this complexity that HT was intended to capture. Moreover, Diane's account of her residential school years, although realized in and fashioned through first-hand encounters and events that she experienced as an individual, was nevertheless a result of Canada's widely enforced "civilization" policy. Thus, her participation in residential school and her vulnerability to traumatic events that occurred there were shared by other Aboriginal people in Canada who were similarly subjected to this form of state-mandated cultural assimilation. Once again, PTSD can be seen as failing to fully account for the collective nature of this shared oppression in which clearly designated Aboriginal groups were deemed racially and culturally inferior. Thus, this identification of a given individual with a class of "problem" person—in this instance by affiliation with a stigmatized ethnoracial group—is what gives rise to the shared significance of personally experienced traumatic stressors.

Furthermore, Diane's formative experiences in residential school appeared to crystallize well beyond her student years into patterns that shaped her adult life. Notably, she referenced this "cycle of abuse" that propelled her through numerous unstable relationships and resulted in the intense anger that rendered her a characteristically violent person. Although PTSD was once theorized to involve a "repetition compulsion" in which an individual unconsciously seeks to reenact an index trauma in order to regain control of the situation (Young, 1995), attention to the accumulation of traumatic experiences over time for "chronically traumatized" individuals that might compound disability and dysfunction in additive fashion led Herman (1997) to advocate for a "new diagnosis" beyond PTSD. It is in this vein that HT more readily captures this facet of traumatic experience. Finally, PTSD is construed as a disorder of the individual lifespan, in which distress and disability follow in the wake of overwhelming experiences that are confronted first-hand. In her account, however, Diane acknowledged the distress that afflicted her own grandmother in the wake of residential schooling, including pronounced anger and a late-life disclosure of sexual abuse. In this reported conversation with her grandmother, Diane also recognized the forward consequences of her own anger and inadequate parenting skills through harsh disciplinary practices toward her children. The tracing of this intergenerational legacy through an ancestral line is precisely what HT was intended to delineate, although Diane herself, it should be noted, made no reference to an inherited vulnerability to

traumatic stressors (although no HT proponent has actually claimed that individuals would be necessarily aware of any inherited vulnerability).

In the end, what most distinguishes Diane's account of HT is not these nuanced attributes that contrast with the established construct of PTSD, but rather her emphasis on indigenous cultural practices as the therapeutic means toward recovery. Indeed, she celebrated the therapeutic approach of the Healing Lodge—which contrasted markedly with other non-Native treatment programs she had attended earlier—for its inclusion and promotion of “Native culture” in support of its First Nations clients. As a function of her engagement in treatment at the Healing Lodge, Diane soon learned to participate in cultural activities such as powwows, sweat lodge ceremonies, and fasting camps. Most significantly, she explicitly linked such participation to shifts in First Nations cultural identity, belonging, and purpose that essentially constituted her “healing journey.” In therapeutic terms, indigenous cultural reclamation fundamentally rejects the assimilationist mandate of the residential schools in service to a “cultural renaissance of the Red Man” (Gone, 2008, 2011b). In the final section of this article, I will offer a rationale for seriously considering the therapeutic potential of First Nations traditional cultural reclamation and revitalization as important means for countering the bitter legacies of colonization.

Culture as treatment: Postulating therapeutic mechanisms

The Manitoba Healing Lodge is not the only tribally controlled treatment program in indigenous communities to adopt and promote a range of activities based on traditional practices as an important component of therapeutic programming. More than a quarter-century ago, Hall (1985) determined that some 45% of alcohol treatment programs funded by the federal Indian Health Service in the U.S. had adopted the sweat lodge as a therapeutic modality—an additional 18% were considering its adoption at that time. Since then, it has become commonplace to both offer and promote talking circles, pipe ceremonies, sweat lodges, and other tribally specific cultural practices for therapeutic purposes within a variety of human services settings that serve First Nations clients (Echo-Hawk et al., in press; French, 2004). The rationale for incorporating such practices within these therapeutic settings is perhaps in equal measures *religious*, *political*, and *pragmatic*. Specifically, in religious terms, participation in indigenous cultural practices—especially ceremonial practices—is widely understood in First Nations contexts to initiate relations with influential other-than-humans who will circulate generative power to tribal members for longevity, prosperity, healing, and wellness (Gone, 2007, 2010). In political terms, participation in indigenous cultural practices is widely recognized as a form of anti- or counter-colonial repudiation of long histories of Euro-centric domination that instead reaffirms the value and vitality of Native life (with salutary psychosocial benefits presumably accruing to those who engage in such practices). Above and beyond these contributions, in pragmatic terms, participation in indigenous cultural practices—especially traditional

healing—is widely believed to be the most efficacious way to assist distressed First Nations individuals due to the inherent potency of these traditions achieved through long pre-contact histories of therapeutic refinement. Even in therapeutic settings where indigenous healing practices are formally absent, token gestures to indigenous cultural practices are thought to at least reassure First Nations clients that available offerings of “mainstream” therapeutic approaches can indeed be made relevant and useful for them, too.

Of course, the various facets of this First Nations therapeutic rationale have rarely been considered in professional circles outside of indigenous community treatment contexts. As a consequence, rigorous evaluation of these claims by skeptical outsiders has not been undertaken; indeed, community-based proponents of this rationale typically see little need for rigorous assessment of these claims and may well reject evaluation efforts by disinvested researchers, owing in part to potentially divergent epistemological commitments (Gone, 2011a, 2012). Nevertheless, the increasingly widespread indigenous claim that “our culture is our treatment” (Gone & Alcantara, 2007) has been so prevalent that some health researchers who have worked in these communities for decades have felt obligated to contend with this assertion in print (Brady, 1995; Weibel-Orlando, 1989). What seems readily apparent from general familiarity with First Nations-controlled therapeutic endeavors is that a project parallel to that undertaken by the mental health establishment is flourishing in these settings. More specifically, according to this alternate indigenous explanatory model, the diagnosis is not the recognized psychiatric categories of major depressive disorder, substance dependence, or PTSD but rather *HT*. Moreover, the treatment-of-choice for this condition is not cognitive-behavioral therapy, flooding, or prescription of SSRI medications but rather *participation in traditional cultural practices*. Finally, the purported explanation for change is not habituation, cognitive reframing, or unmediated alterations in brain chemistry, but rather *spiritual transformations* and accompanying *shifts in collective identity, purpose, and meaning-making*. Given plentiful instances in any community of individuals whose dramatic religious conversions, recast family roles, or even revised occupational opportunities seem sufficient for enabling them to overcome problematic and distressing behaviors, the explanations postulated by First Nations community treatment advocates seem at least plausibly intelligible if not rigorously demonstrated (especially in the context of recovery from substance abuse—typically acknowledged to be one of the foremost features of First Nations HT—where so many indigenous people attribute their enduring sobriety to renewed cultural identification and participation [Gone & Calf Looking, 2011; Spicer, 2001; Whitbeck, Chen, Hoyt, & Adams, 2004]).

Summary elucidation of the First Nations culture-as-treatment claim quite clearly distinguishes this class of proposed cultural interventions from the usual selection of therapeutic approaches deployed by mental health professionals. Especially striking in the current era of evidence-based mental health treatment is the de-emphasis on therapeutic procedure or clinician technique as the presumed mechanism of beneficial change (in contrast to exposure therapy for PTSD, or

relapse prevention for substance dependence, which are indeed named and defined by their technical attributes). Instead, the alleged therapeutic processes entailed in cultural participation are seemingly common to most forms of indigenous healing and ritual participation, recalling the classic cross-cultural explorations of various psychotherapeutic traditions by Jerome Frank. Specifically, Frank and Frank (1993) identified four “effective features” that characterize all “psychotherapies” (construed to explicitly incorporate what they referred to as “religious revivalism” and “religiomagical healing”): (a) “an emotionally charged, confiding relationship with a helping person (often with the participation of a group)” (p. 40); (b) “a healing setting” (p. 41); (c) “a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient’s symptoms and prescribes a ritual or procedure for resolving them” (p. 42); and (d) “a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient’s health” (p. 43). Moreover, these authors highlighted functions—which at least suggest therapeutic mechanisms—commonly served by all healing myths and rituals: “They combat demoralization by strengthening the therapeutic relationship, inspiring expectations of help, providing new learning experiences, arousing the patient emotionally, enhancing a sense of mastery or self-efficacy, and affording opportunities for rehearsal and practice” (p. 44). Thus, Frank and Frank provided a conceptual framework that facilitates the recognition of both professional psychosocial intervention and indigenous traditional healing as two sides of the same therapeutic coin.

The purpose of gesturing toward Frank and Frank (1993) here is to better engage the question of therapeutic mechanisms for the indigenous culture-as-treatment claim more cogently. Specifically, the postulation of mechanisms that might explain therapeutic benefits to First Nations individuals as a consequence of indigenous cultural participation is perhaps most fruitfully discussed in light of the empirical investigations undertaken by psychotherapy process researchers. Currently overshadowed by the pursuit of outcome evidence from randomized controlled trials of psychosocial and psychopharmacological interventions for mental health problems, psychotherapy process research has long contended with the apparent equivalence of psychotherapy outcomes despite diverse theoretical orientations and distinguishing techniques (the so-called “dodo bird verdict,” with reference to Carroll’s *Alice in Wonderland* in which the dodo bird, while sitting in judgment of a chaotic footrace, declared that “everybody has won, and all must have prizes”; Budd & Hughes, 2009, p. 511). In their investigations of psychotherapy process, these researchers have scientifically explored a variety of “common factors” similar to the features and functions reviewed by Frank and others who have attempted to characterize psychotherapy in general terms, independent of specific theoretical commitments or distinguishing techniques (Wampold, 2001). As a counterbalance to growing professional attention to technique-based “empirically-supported treatments” (Chambless & Ollendick, 2001), meta-analytic findings attesting to the potency of *evidence-based psychotherapy relationships* have been generated by psychotherapy process researchers. This

evidence demonstrates the clear contribution of various aspects of one key common factor—the therapeutic relationship—to treatment outcomes, including variables associated with general elements of effective therapist–client interactions (e.g., therapeutic alliance, empathy, client feedback) as well as variables associated with tailoring treatments to the distinctive needs of particular clients (e.g., reactance/resistance, cultural orientation, religious persuasion; Norcross, 2011).

One underappreciated finding of this literature is that common factors—including therapist factors, client factors, and relationship factors—appear to account for roughly 30% of the explained variance in psychotherapy outcomes, while expectancy or “placebo” effects (i.e., hope and assurance from obtaining help) account for an additional 15% of this variance. Given that as much as 40% of explained outcome variance is due to extratherapeutic change (e.g., social support, remission, improved life circumstances), specific therapeutic techniques appear to account for just 15% of the explained outcome variance (Norcross & Lambert, 2011). Thus, the kinds of features and functions identified by Frank and Frank (1993) as shared among healing traditions throughout the world appear to account for as much as three quarters of the outcome variance explained by *in-therapy* attributes and activities (i.e., when disregarding the large extra-therapeutic contribution that lies beyond therapist control). With regard to these provocative findings, it is important to acknowledge that simplistic opposition of technique-driven empirically supported treatments and common factors-driven empirically supported therapy relationships is neither necessary nor useful (Norcross & Wampold, 2011)—even technique-driven interventions are provided in the context of a therapeutic relationship, and therapeutic relationships typically involve some form of procedure, ritual, or technique. Instead, my point here is simply to observe that the therapeutic impact of common factors above and beyond distinctive therapeutic techniques has been compellingly demonstrated for professional psychotherapies and suggests a variety of plausible therapeutic mechanisms that might also account for the alleged efficacy of culture-as-treatment for First Nations distress as well. This is *not* to suggest, of course, that such efficacy *has already* been demonstrated for culture-as-treatment or that all forms of culture-as-treatment would be expected to exhibit *equal* efficacy (indeed, identification of the relevant aspects of First Nations “culture” by indigenous community advocates is a complex topic in its own right). Rather, these are pressing empirical questions, the investigation of which seems warranted in light of the scientifically supported common factors they appear to share with established psychotherapies, as well as the stated First Nations preference for traditions-based therapeutic alternatives to western psychosocial interventions (Gone & Calf Looking, 2011).

Of course, many substantial questions remain about the validity of the culture-as-treatment claim for forms of First Nations distress designated as HT. Given that almost *no* mental health treatments—professional or otherwise—have been evaluated through randomized clinical trials with substantial numbers of indigenous participants (Gone & Alcántara, 2007; Gone & Trimble, 2012), conclusions regarding therapeutic efficacy for *any* form of psychosocial intervention in these

communities remains an open question. Moreover, even if cultural participation—and associated renewals in indigenous identification—was truly efficacious for the many First Nations people who attribute their recovery from chaotic lives to associated mechanisms, it remains a challenge to isolate these processes and practices in the context of the *bricolage* of western and indigenous treatment approaches so frequently found within community programs. Even when such components are recognizably separable, the task of deliberately harnessing the indigenous practices for selective intervention with whatever subset of First Nations individuals would be most likely to benefit is similarly difficult (and there is obviously real variety within indigenous communities as to individual interest in and willingness to participate in Native “traditions” [Csordas, 1999]). Finally, it remains unclear how to operationalize, measure, and ultimately diagnose HT, which as a concept is vulnerable to several formidable critiques, including its simplistic essentializing rhetoric (Gone, in press). Nevertheless, in optimistic partnerships with treatment staffs at urban and reservation treatment programs, respectively (Gone & Calf Looking, 2011; Hartmann & Gone, 2012), I and my collaborators continue to explore the possibility for creating, implementing, and evaluating local cultural alternatives to mental health treatment-as-usual that may one day afford empirical evaluations of the indigenous culture-as-treatment claim.

Conclusion

Disparities in mental health status have been regularly reported for indigenous North American communities. A major source of these disparities appears to be the disproportionately high rates of exposure to potentially traumatic stressors that routinely lead to increased prevalence of PTSD. And yet, professional and community mental health advocates charged with remedying the pathological sequelae of First Nations posttraumatic experiences focus less on PTSD than on historical trauma. In contrast to PTSD, HT is promoted as the more relevant concept, capturing the complex, collective, cumulative, and intergenerational impacts of Euro-American and Euro-Canadian colonization on First Nations peoples. A primary implication of framing First Nations distress as HT is recognition and celebration of an explanatory model that remains alternate and parallel to mainstream professional mental health discourse. This is especially so in terms of the proclaimed treatment for First Nations HT, namely, a return to indigenous traditional practices. More specifically, indigenous cultural practices—of whatever kind find local relevance and meaning—are presumed to remedy HT for various religious, political, and pragmatic reasons. This claim has not been rigorously evaluated relative to First Nations distress; however, plausible therapeutic mechanisms include proposed factors that have been commonly observed across healing traditions throughout the world. I have argued that these factors warrant substantive empirical attention vis-à-vis therapeutic outcomes despite the prevailing psychiatric discourse that routinely privileges the evaluation of therapeutic technique rather than the assessment of therapeutic processes and relationships.

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