

Alternative Knowledges and the Future of Community Psychology: Provocations from an American Indian Healing Tradition

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Abstract In the early years of this globalized century, alternative health knowledges and wellness traditions circulate faster and farther than ever before. To the degree that community psychologists seek collaboration with cultural minority and other marginalized populations in support of their collective wellbeing, such knowledges and traditions are likely to warrant attention, engagement, and support. My purpose in this article is to trace an epistemological quandary that community psychologists are ideally poised to consider at the interface of hegemonic and subjugated knowing with respect to advances in community wellbeing. To this end, I describe an American Indian knowledge tradition, its association with specific indigenous healing practices, its differentiation from therapeutic knowledge within disciplinary psychology, and the broader challenge posed by alternative health knowledges for community psychologists.

Keywords American Indians · Community Psychology · Knowledge systems · Health and wellness · Traditional healing · Indigenous spirituality

[This psychologist named Frank] spoke to me about...his patient. He had many problems which Frank treated, like depression and sadness, but he had one big problem that was beyond Frank's work; the young man had cancer. He had been given four months to live, and now they said he would soon die. Frank

felt that perhaps some new hope and a cure could come from the spirits and our ceremonies, so he asked for help. So I asked my helpers, spirit helpers, for their advice [during a ceremony], and to my surprise they spoke right up. They explained to me that cancer was like a flower. It grows, buds, and blooms. It can continue to grow and become larger and occupy much of the body or it can stop growing and become smaller and then die. Cancer is a living being... My spirits said that they would stop the cancer from growing and budding... If the young man did something else, it might make it go away. What the spirits wanted this young man to do was to go fishing.

—Joseph Eagle Elk (Lakota *heyoka*)

Introduction

At the outset of the millennium, I embarked as a newly minted clinical-community psychologist on a research investigation among my own people, the Gros Ventre of the Fort Belknap Indian reservation in northcentral Montana. For that project, I wished to understand local “explanatory models” for depression and problem drinking based on interviews with tribal community members. One of my respondents, an unusually reflective reservation traditionalist called Traveling Thunder, explained the origins of these “mental health” problems as arising not from polluted genes or broken brains—or even as a legacy of wounded childhood or collective psychic trauma—but rather as a consequence of the colonial subjugation of indigenous ceremonial knowledge and practice (Gone, 2007, 2008b). Loss of ceremonial tradition, he asserted, disrupted long-standing tribal relationships with the Creator, thereby obstructing community access to

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life-generating sacred power that is circulated by such ceremonies. In stark contrast, then, to the rehabilitative mission of reservation-based mental health professionals (who, he observed, routinely engage in cultural forms of “brainwashing”), Traveling Thunder advocated for a collective return to prayer through ceremony as the basis for recovery from rampant (post)colonial pathologies in our communities. This identification of conventional mental health services as expressing a potentially implicit form of hegemonic cultural proselytization (Gone, 2008a) has shaped my program of research in profound ways ever since that formative project. Indeed, it has led me to consider indigenous healing traditions such as the one reflected in the practices of the late Lakota medicine man Joseph Eagle Elk (Mohatt & Eagle Elk, 2000), as specific instances of broader systems of knowledge that are difficult to reconcile with reigning forms of therapeutic authority.

In fact, as part of my scholarly journey, I have documented through several diverse community-based investigations the emergence and establishment of an alternative (or alter-*Native*) discourse concerning American Indian wellness and distress throughout “Indian Country” (Gone & Trimble, 2012). This discourse is both parallel to and divergent from professional knowledge among mental health clinicians and researchers. It speaks to four domains of common concern: the *origins of problems*, *norms of wellbeing*, *approaches to treatment*, and *assessments of outcome*. Regarding the origins of problems, this alternative discourse identifies historical trauma (i.e., the collective, cumulative, and intergenerational impacts of European colonization [Hartmann & Gone, 2016]) as the source of pervasive community dis-order rather than the biological, intrapsychic, and behavioral factors that are typically described as leading to psychopathology. Regarding the norms of wellbeing, this alternative discourse imagines a restoration to local and long-standing forms of indigenous selfhood and relationship (grounded in diverse cultural psychologies [Shweder, 1991]) rather than the enhancement of neoliberal individualist forms of selfhood (i.e., free agents navigating free markets in pursuit of personal happiness [Adams, Dobles, Gomez, Kurtis & Molina, 2015]). Regarding approaches to treatment, this alternative discourse pursues reclaimed indigenous traditional healing practices—especially ceremonial practices—as the means to restoring community members to wellness rather than implementation of established professional mental health treatments—including evidence-based approaches—as the most legitimate forms of therapeutic intervention (Gone, 2009a, 2010, 2011b, 2013). Finally, regarding assessments of outcome, this alternative discourse privileges indigenous ways of knowing rather than scientific

experiments as the preferred means for settling questions of therapeutic efficacy (Gone, 2012).

In commemoration of the 50th anniversary of the establishment of community psychology, I celebrate this important milestone of our profession by considering the *future of alternative knowledges*—especially knowledges in association with health and wellness interventions that lie beyond either disciplinary psychology or biomedicine—in an increasingly diversifying society. I do so from the perspective of this alternative indigenous discourse, with a particular emphasis on indigenous healing traditions. Paradoxically, with respect to most things indigenous (whether cultural, epistemological, or therapeutic), to look forward is also to look backward so as to trace lines of continuity and to harvest insights from histories of both subjugation and “survival” (Vizenor, 1999). In this instance, I examine a particular indigenous knowledge tradition—specifically a Teton Sioux or Lakota knowledge tradition—as just one representative of a plethora of peripheral knowledge traditions that might give rise to culturally alternative health claims, including cultural meta-claims about knowing that may in fact be required for proper adjudication of such claims. This Lakota knowledge tradition is associated with the *heyoka* role made famous by Lakota holy men such as Nicholas Black Elk, whose visionary experiences continue to be circulated to an inspired readership around the world (Neihardt, 2014). My ultimate purpose is to trace an epistemological quandary with which community psychologists are ideally poised to grapple at the interface of hegemonic and subjugated knowing. To this end, I will describe the Lakota *heyoka* tradition, its association with specific healing practices that are embedded within a broader knowledge system, the differences between Lakota therapeutic knowledge and that of professional psychology, and the broader challenge posed by alternative health knowledges for future community psychologists.

Black Elk and the *Heyoka* Tradition

One area of my scholarship concerns traditional healing among northern Plains Indian peoples. For example, I have analyzed the narrative of *Bull Lodge's Life*, written by my great grandfather Fred P. Gone in 1941, which recounts the events and actions associated with the most famous medicine person among the Gros Ventre. My analyses of this narrative have produced insights into the nature of American Indian traditional healing vis-à-vis modern psychotherapy (Gone, 2010), the importance of place for the practice of Native healing (Gone, 2009b), the generative power circulated by narrative accounts of signature life events such as war stories (Gone, 2011a),

and the indigenous functions served by multigenerational preservation of this particular life narrative (Gone, 2006). For this article, I examine relevant portions of John Neihardt's interviews (DeMallie, 1984) with the Oglala Lakota holy man and healer, Nicholas Black Elk (*Hehaka Sapa*, 1863–1950), undertaken prior to Neihardt's (2014) completion of *Black Elk Speaks*. Owing to Neihardt's publication of this work, Black Elk has become practically synonymous with indigenous spirituality around the world—although the book was a commercial failure when it was first published in the 1930s, it was rediscovered in the 1960s and was subsequently circulated both widely and ardently. It would thus seem that consideration of Black Elk's "great vision" (like consideration of Bull Lodge's "seven visions") could illuminate questions at the intersection of alternative indigenous knowledge and community psychology.

At the age of five, Black Elk ventured into a nearby wood to shoot a bird with his bow and arrow. As a thunder storm approached, a voice directed Black Elk's attention to "two men coming out of a cloud with spears" from the north (DeMallie, 1984, p. 109). A nearby bird announced the arrival of the men, who approached from above while singing a sacred song. They then turned west, and transformed into geese. Black Elk explained that this experience was not a dream, but occurred when he was awake and lasted about 20 minutes in duration. At the age of nine, while eating supper as a guest of an individual named Man Hip, Black Elk heard a voice say, "It is time, now they are calling you" (p. 111). As he departed his host's lodge, he experienced debilitating pain in his thighs. The next day, he collapsed and was unable to walk. While lying unconscious in the family lodge for the next 12 days, he experienced the vision that would preoccupy him for the remainder of his life. It was a complex experience involving communication from the Thunder beings in the west, and gifts of power from grandfathers sitting in the cardinal directions. These gifts included power for life-generating activities on behalf of his people (e.g., a sacred herb for healing) and life-destroying activities against tribal enemies (e.g., a spear with lightning power) (these latter gifts were deliberately excised by Neihardt from his book). In his great vision, Black Elk himself was identified as the sixth grandfather representing humankind. From this vision have come widespread pan-Indian references to the "flaming rainbow" in the west, the "sacred hoop" of the nation, the "good red road" that runs from south to north, and the "tree of life" that sits in the center of a great circle.

This vision troubled Black Elk from time to time during his youth. When he was sixteen years of age he was "overcome by obsessive fear" of summer storms (DeMallie, 1984, p. 6) because "thunder dreamers" were culturally obliged to ritually announce their powers to the community

or otherwise live in danger of imminent death from lightning. Black Elk finally confided his vision to an older holy man named Black Road and subsequently fulfilled this obligation to the Thunder beings by sponsoring the *heyoka* ceremony when he was seventeen. *Heyokas* were Lakota individuals who had received such dreams or visions from the Thunders, which designated them to perform the role of ritual jesters or sacred clowns. They were recognized as holy men who paradoxically reinforced the social order by acting in contrary fashion, routinely challenging common sense and established sensibility. *Heyokas* thus contributed to the Lakota community by upending conventions, satirizing authority, and pushing the boundaries of taken-for-granted morality, typically in ridiculous or humorous ways (such as plunging their hands into boiling water only to complain that it was too cold). Moreover, *heyokas* exercised therapeutic powers. Thus, at the age of nineteen, Black Elk initiated his healing practice by ritually curing the young son of Cuts to Pieces. Black Elk's curing rites involved a pipe, drum, whistle, herb, and wooden cup. In his vision, the six grandfathers had each presented him with a cup of water to drink. The cup from the second (north) grandfather contained a small blue man with a bow and arrow whom Black Elk was instructed to swallow—during his conjuring ceremonies, Black Elk could regurgitate this being (also referred to as a "fish") back into the cup. Black Elk thus became recognized for his healing power among the Oglalas.

As local Jesuits consolidated their power, however, they denounced such ceremonies as spiritually diabolical and on occasion literally disrupted them. It seems that Father Aloysius Bosch, S.J., intruded on Black Elk in 1902 and destroyed his ritual implements—this priest was killed shortly thereafter when thrown from a horse. And in 1904, when Black Elk was around 40 years of age, Father Joseph Lindebner, S.J., arrived to administer last rites to a boy whom Black Elk was treating. Father Lindebner stopped Black Elk's ritual, cast his implements out of the lodge, and seized him by the neck, shouting "Satan, get out!" (DeMallie, 1984, p. 14). Black Elk was so demoralized by this event—according to his daughter, he may have concluded that the priest's powers were greater than his own—that he converted to Roman Catholicism, never to perform his ceremonies again (even in response to Neihardt's pleading requests). He became a well-known and respected Catholic catechist on the reservation and served as a lay missionary to other reservations on the northern Plains, where his Indian converts over subsequent decades reached into the hundreds. Interestingly, following his final interview with Neihardt in 1931 (when he was 67 years old), Black Elk climbed to the summit of Harney Peak in the Black Hills of South Dakota and prayed to the grandfathers for his people to reenter the sacred hoop. When Neihardt's account of this

hilltop prayer appeared in *Black Elk Speaks*, it caused considerable trouble for Black Elk at the Pine Ridge reservation because his reputation had been built on devotion *not* to the Lakota grandfathers but to Christianity. Two years later, Black Elk was thrown from his wagon, run over, and nearly succumbed to his injuries. Subsequent to this event, in 1934 he circulated a signed and witnessed statement reaffirming his fervent devotion to Catholic beliefs and practices.

Eagle Elk and Therapeutic Knowledge

Because the goal of this article is to reflect on the *future* of community psychology, it is crucial to note that the *heyoka* tradition—and its associated healing practices—did not die with Nicholas Black Elk but continues to endure within Lakota communities today. Importantly, the persistence of this knowledge tradition was documented by community psychologist Gerald Mohatt in partnership with the Sicangu Lakota *heyoka*, Joseph Eagle Elk (1931–1991). Their book (Mohatt & Eagle Elk, 2000) stands today as an exemplar of knowledge exchange within our discipline and recounts how Eagle Elk became a medicine man on the Rosebud Sioux reservation. Like Black Elk, he, too, was chosen by the lightning, performed the *heyoka* ceremony, obtained other forms of healing power, and ritually “doctored” many community members during his remarkable career. According to Eagle Elk, the life of a medicine man is arduous, one that continuously obligates an individual to community members as well as to other-than-human sponsors whose ways are regularly mysterious and sometimes frightening. Indeed, neither Nicholas Black Elk nor Joseph Eagle Elk welcomed the attention of the Thunders, but rather denied and resisted the gift of *heyoka* status throughout their adolescent years, disrupting their own peace of mind until eventually coming to terms with “the price of a gift.” Interestingly, the collaboration between Mohatt and Eagle Elk depended on one aspect of that gift, namely, a shared foundation of case-based insight achieved through therapeutic engagement with patients (captured in a fascinating appendix to the book comprised of a transcript of conversations between Lakota traditionalists from South Dakota and Lacanian psychoanalysts from France). As a result, the book affords a distinctive window on more recent Lakota therapeutic knowledge.

And so, I return now to the epigraph of this article, in which Eagle Elk described one of his more compelling cases. A psychologist friend, called Frank, was treating a dying man. Frank wondered if Eagle Elk’s ceremonies could help. Eagle Elk consulted his other-than-human sponsors. Their recommendation was for the dying man to go fishing.

He would go fishing, and once he caught the fish he was to take it in his hands and look it in the eye and say to it that he wished it a long life. He should talk to the fish. The fish would speak to the young man and he was to speak back to the fish. . . . Only this young man could maybe understand the fish and only this young man could speak what was to be said. . . . What the spirits said is that he should speak to him about his sickness and then return the fish to the water. They thought that the fish would take something with him. We don’t know what. Well, I told Frank what to tell his patient and what to do.

(Mohatt & Eagle Elk, 2000, pp. 102–103)

The psychologist and his patient (after many failed attempts to meet) did eventually go fishing. The patient caught the fish and held it in his hands as prescribed. He spoke to it. The fish responded by making a sound “almost like a cat’s cry, and it happened twice” (p. 104). The patient did not understand what the fish had said. Nevertheless, with great excitement, the patient released the fish. “Unfortunately, [the patient] was not able to throw away the cancer with the fish by finding the words that would talk to the fish.” He died just over a year later.

Eagle Elk seems to have ruminated about this case, explaining that: “It is one case which I have not understood well and one that made me question why did things go the way they went. . . . This case became a puzzle for me” (Mohatt & Eagle Elk, 2000, p. 102). His summary reflections in this chapter of the book titled, “The Fish and the Man,” are illuminating:

I wished there was another way, but there wasn’t. The young man and his friend were. . . sort of stalled in between my ways and their ways. And this in between made it really hard for them to meet [to go fishing]. They did not really understand the Lakota way or my way of doctoring. He and Frank both had a desire to believe in the Lakota medicine but couldn’t lend their whole mind to our ways. If he would have come to me immediately after the fish spoke to him and put up a ceremony, the spirits could have told him what the fish said, but he didn’t. Even if he didn’t really believe, he could have asked and they could have told him. Whether things would have turned out different if he had done this I don’t know, but he would have known what the fish said to him. I really felt pity for them. But this is the way it happened.

(pp. 104–105)

Thus, Eagle Elk suggested, the failure of this patient to recover from his illness may have resulted from his

position “in between” biomedicine and Lakota medicine, such that neither the patient nor his psychologist could “lend their whole minds to our ways.” Still, despite the patient’s disbelief, he could have sponsored the ceremony anyway to learn what the fish had communicated. It was unclear to Eagle Elk whether this would have altered the outcome for the patient, but because he chose otherwise no one would ever know for sure. Eagle Elk concluded, “the young man lived with the words of the fish and felt much better and was more confident that he was going to a better place” (p. 105).

Therapeutic Practice and Knowledge Systems

My purpose in reviewing the indigenous *heyoka* tradition among the Lakota was to illustrate a specific form of alternative knowledge with clear ties to contemporary therapeutic practice that contrasts remarkably with the assumptions, logics, and procedures of biomedicine. Community psychologists, of course, have long contested the dominance of biomedical injunctions in the helping professions, especially as these came to shape the development of clinical psychology. For instance, Albee (1998) denounced psychology’s acceptance of the “narrow medical model” as a diabolical transaction (i.e., “selling our soul to the devil,” p. 192), and Rappaport and Seidman (1983) overtly contrasted clinical psychology and community psychology in terms of divergent approaches (reflecting differing modes of intervention, conceptions of individual behavior, and conceptions of society) that span four conceptual elements (target, content, process, and knowledge). In short, community psychology’s celebrated secession from clinical psychology fifty years ago was premised on commitments to alternative ambitions, objectives, principles, and politics in comparison to what had become normative in the discipline during the first decades after the Second World War (Altman, 1987; Anderson et al., 1966; Iscoe, Bloom & Spielberger, 1977).

Community psychology has since been distinguished by dedication to collaboration, empowerment, diversity, and prevention, stemming from empirical, ecological, critical, and contextual analysis (Rappaport, 1977). These commitments have further obligated community psychologists to invoke, justify, and defend alternative approaches to knowledge production (Rappaport, 2005; Tebes, 2005; Trickett, 2009). Thus, a reflexive, open-minded, and self-critical examination of knowledge would not be unfamiliar to most community psychologists, which is why I believe that brief but substantive consideration of the *heyoka* tradition will illuminate complex tensions that community psychology must be prepared to engage in an increasingly globalized future. Black Elk’s vision—and his associated life

experience—affords an opportunity for exploring the relationship of such knowledge to therapeutic intervention. In this respect, Castellano (2000) noted certain characteristics of indigenous knowledge: “Aboriginal knowledge is said to be personal, oral, experiential, holistic, and conveyed in narrative or metaphorical language” (p. 25). These seem to characterize Black Elk’s healing knowledge and power.

Specifically, Black Elk’s therapeutic knowledge was *personal* in that it depended on his own vision, an experience that he was rarely supposed to share—in fact, he noted while recounting his vision to Neihardt that “he has a queer feeling all the time he is telling this, and that he is giving his power away” (DeMallie, 1984, p. 126). His healing knowledge was *oral* in that no documentary record of his power existed prior to the stenography undertaken by Neihardt’s daughter in the context of collaboration between Black Elk and Neihardt. Likewise, this knowledge was *experiential* in that it came to him through his vision and subsequent practice without any mention of a healing apprenticeship—rather Black Elk explained that “I had never received instructions from anyone, but I just fixed a way for my curing” (p. 236). Black Elk’s healing knowledge was *holistic* (in Castellano’s [2000] sense) by virtue of involving ceremony to address illness across the now readily distinguished domains of body, mind, and spirit through engagement with the social (e.g., involving family members) and environmental (e.g., involving locally available herbs). Finally, there can be little question that Black Elk’s healing knowledge, emerging as it did from his highly symbolized vision, was *metaphorical* in nature—he evidently grappled with the meaning of the vision for himself and for his people during his entire life.

The relevant knowledge entrusted to Nicholas Black Elk (and later, to Joseph Eagle Elk) was principally of the *sacred* or *revealed* kind (Castellano, 2000). This obviously stands in stark contrast to the practices of knowledge production that are privileged in psychological science in general, and in psychological clinical science more specifically. Psychological clinical scientists routinely distinguish their activities by describing professional practice as an applied science dependent on the identification, adoption, and dissemination of empirically supported treatments (ESTs) for mental health problems (Baker, McFall & Shoham, 2009; McFall, 1991). This commitment of psychological clinical science to the promotion of ESTs has been widely acknowledged, and alternately celebrated or critiqued—owing to their appreciation of contextual influences, community psychologists have been less credulous than other disciplinary constituencies (Hawe, Shiell & Riley, 2004, 2009; Trickett et al., 2011). For purposes of making apparent a quandary in our own subfield, it is useful to observe several recognizable assumptions that undergird the promotion of ESTs in the helping

professions, and then to contrast these with the less familiar assumptions undergirding Lakota therapeutic knowledge that persists in practice to this day (Gone, 2010).

Diverse Therapeutic Knowledges

For psychological clinical science, the post-Enlightenment synthesis of rationalism and empiricism has coalesced into a style of reasoning, labeled scientific, that is familiar to all psychologists (Schafersman, 2011). First, it is this style of reasoning that privileges the adoption of the randomized controlled trial as the arbiter of causal claims in the development and legitimation of ESTs within health services psychology. Second, on the basis of this style of scientific reasoning, the promotion of ESTs implies a standardization of clinical practice, reducing the variety of therapeutic approaches and techniques available to patients relative to current overall offerings in professional treatment. Third, the promotion of ESTs presumes that therapeutic efficacy depends more so on treatment technique than on other variables associated with the clinical encounter, such as different facets of the therapeutic relationship. Fourth, the promotion of ESTs depends on the interchangeability of treatment professionals, such that most properly trained clinicians could be expected to implement a given treatment in effective fashion with their patients. Finally, the promotion of ESTs construes clinician expertise as a combination of technical proficiency and responsiveness to patients in the administration of treatments, but fidelity to treatment technique is much more heavily emphasized than the ability to tailor treatments to patients on an ad hoc basis. In sum, psychological clinical scientists consistently stress the *technical* over the relational in the delivery of treatment services (Gone, 2010).

In contrast, therapeutic knowledge represented by the *heyoka* tradition and exemplified in the practices of Joseph Eagle Elk (Mohatt & Eagle Elk, 2000) operate according to markedly different logics and assumptions. First, while Lakota doctoring practices appear to adhere to broad cultural patterns, the specific curing rituals performed by any particular healer are revealed to that individual by other-than-human sponsors, and remain both distinctive and secret. Second, although Lakota doctoring may involve a standardized ritual protocol for summoning other-than-human helpers, the prescribed treatments that result may be completely idiosyncratic to a given patient. Third, in Lakota doctoring, therapeutic efficacy depends on the healer's relationships to both humans and other-than-humans for the exercise of sacred power in support of patient recovery—it is the mediation and management of these relationships that constitutes therapeutic expertise. Fourth, in Lakota doctoring, therapeutic expertise lies in

the particular powers gifted by the healer's specific other-than-human helpers such that healers are not readily interchangeable but rather remain the single most important therapeutic "variables". Finally, in Lakota doctoring, ceremony occasions an encounter in which the concentration of collective will or wish (i.e., "lending one's whole mind") among all participants is thought to have the potential to create an altered reality that includes therapeutic benefit. In sum, Lakota therapeutic practitioners understand that *relational* processes rather than any technical mechanisms are what rekindle, expand, and extend vitality and liveliness on behalf of patients (Gone, 2011a).

The technical-relational divergence between the logics of ESTs and Lakota healing tradition, respectively, is only one domain of difference at play between these therapeutic approaches (Gone, 2010). I have emphasized this form of divergence because it highlights a quandary pertaining to knowledge traditions that I predict will only expand as community psychologists confront an increasingly globalized future. More specifically, the contrast of evidence-based practice and the Lakota *heyoka* tradition hinges on the fact that ESTs are designed to express nomothetic knowledge—i.e., forms of understanding that are general across cases and applicable to individuals only in probabilistic terms—while Lakota ritual healing practices convey idiographic knowledge—i.e., forms of understanding that are distinctive to a given case and applicable only to a unique individual—in support of patient benefit. Thus, an EST such as Cognitive-Behavioral Treatment might be recommended for any patient who meets the diagnostic criteria for Major Depressive Disorder, whereas a prescription to catch, address, and release a fish might never have been (and may well never be again) recommended to any other patient besides the young man whose psychologist consulted Joseph Eagle Elk on his behalf. With specific regard to this Lakota doctoring case, then, the question arises: Could there even be an evidence-based form of this traditional Lakota healing practice?

The Challenge of Alternative Health Knowledges

There are at least four different stances one can assume in response to this question, two of which are each embedded within whether one first answers yes or no. If one answers yes to this question, *affirming that* such Lakota healing practices are in principal amenable to ultimate designation (or not) as ESTs, then one would first have to shift a level of abstraction higher than the actual case-based prescriptions of other-than-human helpers who have been consulted by Lakota healers. That is, in order to remedy the recalcitrantly idiographic character of a "fishing" treatment for cancer, one would presumably instead need to

formulate the pertinent therapeutic intervention as ceremonial “spirit consultation.” In so doing, one would need to answer a second question, subordinate to the first: If yes, what is gained and lost by evaluating Lakota doctoring practices in this way? Consider two alternative responses. The first emphasizes the possible gains associated with scientific legitimacy, government recognition, and access to funding, which could support community-controlled expansion of formerly subjugated knowledges and practices (all assuming the results of scientific outcome evaluation were favorable). A second response emphasizes the possible losses associated with altered traditions, government intrusion, and epistemic violence, which could further undermine the autonomy, integrity, and persistence of these formerly subjugated knowledges and practices (especially if the results of scientific outcome evaluation were unfavorable). As an American Indian psychologist, I have never encountered either Native community members or other Native health professionals who propose or suggest that Lakota or other forms of indigenous traditional healing should or could become evidence-based in the formal sense of this designation (Gone & Alcántara, 2007).

In contrast, if one answers no to the overarching question, *denying that* such Lakota healing practices are in principal amenable to ultimate designation (or not) as ESTs, then one would ask a second, subordinate follow-up question: If no, what is the relevance of Lakota doctoring practices for wellness interventions and biomedically dominated healthcare services? Again, I suggest two possible responses. The first asserts that Lakota doctoring remains highly relevant for wellness interventions and healthcare services even though it is not amenable in principal to scientific evaluation. There are several ways one might make this case, such as the inclusion of Lakota healers as adjunct providers within the biomedical care system or the incorporation of Lakota therapeutic knowledge into local service provision and cultural competence training. This reflects what I have routinely heard throughout “Indian Country,” that “we already know what works in our communities” with reference to indigenous traditional practices—such claims seem to reflect the vaunted authority of personal experience within indigenous knowledge systems (Gone, 2012). Other American Indian professionals and advocates have asserted even more direct relevance on the grounds of “practice-based evidence” in surprisingly influential ways (Echo-Hawk et al., 2011), leading to government openness toward funding traditional interventions of various types—these efforts tend to represent political achievements more so than bona fide epistemological reconciliation. Alternately, a second response asserts that Lakota doctoring is simply *not* relevant for wellness interventions and healthcare services precisely because it is not amenable in principal to

scientific evaluation. Proponents of this view would remain comfortable with a strict segregation of therapeutic authority and legitimacy, recognizably akin to the perspective of the champions of psychological clinical science and evidence-based medicine more generally.

These alternate views underlie a quandary for community psychologists in the context of the proliferation of alternative health knowledges in our increasingly globalized future. For, just as the knowledge and traditions of biomedicine have circulated around the world, so too do culturally unfamiliar therapeutic traditions arrive daily at our doorsteps. In light of the recognized limitations of biomedicine (which is not at all to denigrate its many, truly stunning contributions), alternative health knowledges are here to stay. And so, what will community psychology make of such knowledges? Will we align with our epistemologically skeptical and methodologically conservative colleagues in advancing the cause of (perhaps a reformed vision or revised version of) science, extending the authority of credentialed knowledge, and protecting the integrity of professional practice, thereby risking the further hegemonic marginalization of long-subjugated knowledges? Or will we align with our disenfranchised and dismissed community partners in advancing local forms of knowledge, extending our admiration, acceptance, and endorsement of their claims, and protecting their beleaguered practices from skepticism and dismissal by authoritative outsiders? As community psychologists, will we “lend our whole minds” to these traditions, or rather get “stalled in between” their ways and our ways? In this neoliberal age, will we advocate for allocation of scarce healthcare resources toward making scientifically vetted treatments more widely available, or rather pursue resources to support interventions for which scientific outcome evaluation may not be possible? Will we favor our enlightenment heritage (i.e., rationalism and skeptical empiricism), or rather our romantic heritage (i.e., contextualism and cultural relativism) with respect to alternative knowledge claims (Shweder, 1984)? Will we side with evidence-based practice or practice-based evidence? And, is consensus on these questions within community psychology either possible or desirable?

Regardless of how we address this quandary, as community psychologists we are collectively assured of the obligation to grapple with these questions as the new millennium continues to unfurl.

References

- Adams, G., Dobles, I., Gomez, L.H., Kurtis, T., & Molina, L.E. (2015). Decolonizing psychological clinical science: Introduction to the special thematic section. *Journal of Social and Political Psychology*, 3, 213–238.

- Albee, G.W. (1998). Fifty years of clinical psychology: Selling our soul to the devil. *Applied and Preventive Psychology*, 7, 189–194.
- Altman, I. (1987). Community psychology twenty years later: Still another crisis in psychology? *American Journal of Community Psychology*, 15, 613–627.
- Anderson, L.S., Cooper, S., Hassol, L., Klein, D.C., Rosenblum, G., & Bennett, C.C. (Eds.) (1966). *Community psychology: A report of the Boston conference on the education of psychologists for community mental health*. Quincy, MA: South Shore Mental Health Center.
- Baker, T.B., McFall, R.M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental health behavioral health care. *Psychological Science in the Public Interest*, 9, 67–103.
- Castellano, M.B.. (2000). Updating Aboriginal traditions of knowledge. In G.J. Sefa Dei, B.L. Hall, & D.G. Rosenberg (Eds.), *Indigenous knowledges in global contexts: Multiple readings of our world* (pp. 21–36). Toronto: University of Toronto Press.
- DeMallie, R.J. (Ed.) (1984). *The sixth grandfather: Black Elk's teachings given to John G. Neihardt*. Lincoln, NE: University of Nebraska Press.
- Echo-Hawk, H., Erickson, J.S., Naquin, V., Ganju, V., McCutchan-Tupua, K., Benavente, B., ... & Alonzo, D. (2011). *The compendium of behavioral health best practices for American Indian, Alaska Native, and Pacific Island indigenous populations: A description of selected best practices and cultural analysis of local evidence building*. Portland, OR: First Nations Behavioral Health Association.
- Gone, J.P. (2006). "As if reviewing his life": Bull Lodge's narrative and the mediation of self-representation. *American Indian Culture and Research Journal*, 30, 67–86.
- Gone, J.P. (2007). "We never was happy living like a Whiteman": Mental health disparities and the postcolonial predicament in American Indian communities. *American Journal of Community Psychology*, 40, 290–300.
- Gone, J.P. (2008a). Introduction: Mental health discourse as Western cultural proselytization. *Ethos*, 36, 310–315.
- Gone, J.P.. (2008b). "So I can be like a Whiteman": The cultural psychology of space and place in American Indian mental health. *Culture & Psychology*, 14, 369–399.
- Gone, J.P. (2009a). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting & Clinical Psychology*, 77, 751–762.
- Gone, J.P.. (2009b). "Three places where I was given the power to heal and cure": *Convergences of place, health, and experience*. Unpublished manuscript, Department of Psychology, University of Michigan, Ann Arbor, Michigan.
- Gone, J.P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist*, 38, 166–235.
- Gone, J.P. (2011a). "I came to tell you of my life": Narrative expositions of "mental health" in an American Indian community. In M. Aber, K. Maton, & E. Seidman (Eds.), *Empowering settings and voices for social change* (pp. 134–154). New York: Oxford University Press.
- Gone, J.P. (2011b). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology*, 47, 187–202.
- Gone, J.P. (2012). Indigenous traditional knowledge and substance abuse treatment outcomes: The problem of efficacy evaluation. *American Journal of Drug and Alcohol Abuse*, 38, 493–497.
- Gone, J.P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry*, 50, 683–706.
- Gone, J.P., & Alcántara, C. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural Diversity & Ethnic Minority Psychology*, 13, 356–363.
- Gone, J.P., & Trimble, J.E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131–160.
- Hartmann, W.E., & Gone, J.P. (2014). American Indian historical trauma: Community perspectives from two Great Plains medicine men. *American Journal of Community Psychology*, 54, 274–288.
- Hartmann, W.E., & Gone, J.P. (2016). Psychological-mindedness and American Indian historical trauma: Interviews with service providers from a Great Plains reservation. *American Journal of Community Psychology*, 57, 229–242.
- Hawe, P., Shiell, A., & Riley, T. (2004). Complex interventions: How "out of control" can a randomised controlled trial be? *British Medical Journal*, 328, 1561–1563.
- Hawe, P., Shiell, A., & Riley, T. (2009). Theorising interventions as events in systems. *American Journal of Community Psychology*, 43, 267–276.
- Iscove, I., Bloom, B.L., & Spielberger, C.D.. (Eds.) (1977). *Community psychology in transition: Proceedings of the National Conference on Training in Community Psychology*. Washington, DC: Hemisphere Publishing.
- McFall, R.M. (1991). Manifesto for a science of clinical psychology. *The Clinical Psychologist*, 44, 75–88.
- Mohatt, G., & Eagle Elk, J. (2000). *The price of a gift*. Lincoln, NE: University of Nebraska Press.
- Neihardt, J.G. (2014). *Black Elk speaks: The complete edition*. Lincoln, NE: University of Nebraska Press.
- Rappaport, J. (1977). *Community psychology: Values, research, and action*. Fort Worth, TX: Holt, Rinehart, and Winston.
- Rappaport, J. (2005). Community psychology is (thank God) more than science. *American Journal of Community Psychology*, 35, 231–239.
- Rappaport, J., & Seidman, E. (1983). Social and community interventions. In C.E. Walker (Ed.), *The handbook of clinical psychology: Theory, research, and practice*, vol II (pp. 1089–1122). Homewood, IL: Dow Jones-Irwin.
- Schafersman, S.. (2011). An introduction to science: Scientific thinking and the scientific method. In S.O. Lilienfeld & C.T. O'Donohue (Eds.), *Great readings in clinical science: Essential selections for mental health professionals* (pp. 21–25). New York: Pearson.
- Shweder, R.A. (1984). Anthropology's romantic rebellion against the enlightenment, or there's more to thinking than reason and evidence. In R.A. Shweder & R.A. LeVine (Eds.), *Culture theory: Essays on mind self, and emotion* (pp. 27–66). Cambridge: Cambridge University Press.
- Shweder, R.A. (1991). *Thinking through cultures: Expeditions in cultural psychology*. Cambridge, MA: Harvard University.
- Tebes, J.K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology*, 35, 213–230.
- Trickett, E.J. (2009). Community psychology: Individuals and interventions in community context. *Annual Review of Psychology*, 60, 395–419.
- Trickett, E.J., Beehler, S., Deutsch, C., Green, L.W., Hawe, P., McLeroy, K., ... & Trimble, J.E. (2011). Advancing the science of community-level interventions. *American Journal of Public Health*, 101, 1410–1419.
- Vizenor, G. (1999). *Manifest manners: Narratives on postindian survivance*. Lincoln: University of Nebraska Press.