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Article

Rethinking cultural competence: Insights from indigenous community treatment settings

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Abstract

Multicultural professional psychologists routinely assert that psychotherapeutic interventions require culturally competent delivery for ethnoracial minority clients to protect the distinctive cultural orientations of these clients. Dominant disciplinary conceptualizations of cultural competence are "kind of person" models that emphasize specialized awareness, knowledge, and skills on the part of the practitioner. Even within psychology, this approach to cultural competence is controversial owing to professional misgivings concerning its culturally essentialist assumptions. Unfortunately, alternative "process-oriented" models of cultural competence emphasize such generic aspects of therapeutic interaction that they remain in danger of losing sight of culture altogether. Thus, for cultural competence to persist as a meaningful construct, an alternative approach that avoids both essentialism and generalism must be recovered. One means to capture this alternative is to shift focus away from culturally competent therapists toward culturally commensurate therapies. Indigenous communities in North America represent interesting sites for exploring this shift, owing to widespread political commitments to Aboriginal cultural reclamation in the context of postcoloniality. Two examples from indigenous communities illustrate a continuum of cultural commensurability that ranges from global psychotherapeutic approaches at one end to local healing traditions at the other. Location of culturally integrative efforts by indigenous communities along this continuum illustrates the possibility for local, agentic, and intentional deconstructions and reconstructions of mental health interventions in a culturally hybrid fashion.

Keywords

cultural competence, multicultural counseling, evidence-based practice, indigenous peoples, First Nations peoples, American Indians

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In pluralist societies of the West, the aspiration to provide health care to diverse constituencies is a standing ethical commitment. Nevertheless, the question of how best to ensure routine access to high-quality care in the context of cultural diversity and structural inequality remains a formidable challenge. Although persistent health disparities have been widely observed based on ethnoracial and socioeconomic status, for example, straightforward practical solutions for redressing these disparities are typically elusive (American Psychological Association, 2003; D. W. Sue & D. Sue, 2002; U.S. Department of Health and Human Services, 2001). One promising domain of intervention within health care professions and services has come to be labeled cultural competence (S. Sue, Zane, Hall, & Berger, 2009). Cultural competence refers to attributes or characteristics of service providers (and, sometimes, service agencies and organizations) that equip them to effectively provide otherwise desirable or warranted health care interventions to an array of culturally diverse patients or clients.

Cultural competence has gained considerable popularity in recent decades, especially among professional psychologists and other mental health practitioners and organizations concerned with multicultural practice. However, the construct remains controversial because of concerns about its purportedly atheoretical nature, its limited empirical support, its questionable feasibility, and its possible association with cultural essentialism (see, e.g., Lakes, López, & Garro, 2006; S. Sue et al., 2009). As a result, several scholars are beginning to rethink cultural competence in an effort to remedy these concerns while retaining a substantive focus on cultural difference.

In this article, we propose an alternative approach to cultural competence that appraises the cultural commensurability between the shared meanings and practices that structure everyday life for any given marginalized population and those that comprise contemporary counseling and psychotherapy. In this regard, we focus primarily on professional psychology in the United States, although to our knowledge most of our arguments apply to western health care services generally. After providing a brief introduction to cultural competence, we address what we consider to be perhaps the most pressing conceptual and practical difficulties of this popular construct: (a) the tenuous relationship between specific cultural competencies and general clinical competence, and (b) the primary focus on producing culturally competent therapists alongside minimal consideration of the actual (western) cultural constituents of psychotherapy per se. We then draw upon recent efforts in the development of Native or indigenous community-based treatments in order to articulate a shift from culturally competent therapists to culturally commensurate therapies.

Conceptualizing cultural competence within professional psychology in the United States

The development of guidelines and standards for cultural competence in American psychology followed on the heels of the American Civil Rights movement

(Arredondo & Perez, 2006). Professional transformations included the establishment of ethnoracial minority psychology associations (e.g., the Society of [American] Indian Psychologists) that formulated penetrating critiques of monocultural Euro-American assumptions and biases that historically dominated the discipline. In addition to concerns about scientific racism, critics also objected to serious limitations in the conventional practice of psychological assessment and intervention with culturally diverse populations (American Psychological Association, 2003; D. W. Sue & D. Sue, 2002). Cultural competence soon emerged as a means to remedy the perceived irrelevance, alienation, and even harm that might befall ethnoracially diverse clients seeking mainstream treatment from Euro-American therapists.

Specific cultural competencies versus general clinical competence

The initial and perhaps dominant mode of cultural competence stresses specific attributes or characteristics of individual practitioners. In recent decades, D. W. Sue and colleagues (Sue, Arredondo, & McDavis, 1992; D. W. Sue et al., 1982; Sue et al., 1998) have developed extensive lists of specific competencies pertaining to counselor self-awareness, client worldview, and intervention strategies. The most elaborate and visible construction of cultural competence is D. W. Sue's (2001) threefold model of cultural competence that integrates (a) five race- and culture-specific constituencies who merit such competence (African Americans, Asian Americans, Latino Americans, Native Americans, and European Americans); 31 specific competencies divided into three domains (beliefs/attitudes, knowledge, and skills); and four "foci" or levels of analysis to which cultural competence should apply (individual, professional, organizational, and societal).

Although D. W. Sue's (2001) model of cultural competence is quite comprehensive in scope, the concrete implications for workaday clinical encounters are most evident in the second dimension (i.e., specific competencies). These competencies, adapted from Sue's earlier work (D. W. Sue et al., 1992), comprise what has been termed a "kind-of-person model" of cultural competency (see S. Sue et al., 2009), where focus is placed on personal attributes of the practitioner—the kind of person s/he needs to be. Example competencies include being "comfortable with differences that exist between themselves and others" (beliefs/attitudes), being "able to acknowledge own racist attitudes, beliefs, and feelings" (knowledge), and being "involved with minority groups outside of work role" (skills; D. W. Sue, 2001, p. 799).

This focus on specific therapist competencies likely reflects a professional desire for straightforward guidelines or recommendations—perhaps accompanied by a checklist or rating scale—that might unambiguously delineate competence in cross-cultural therapeutic encounters. Moreover, the application of these competencies in the realm of specific ethnoracial minority groups may help to draw attention to mental health disparities among these groups—an important reason for the development of cultural competence in the first place (S. Sue et al., 2009).

Indeed, judging from the contents of standard multicultural counseling texts, there is a clear demand for compartmentalized treatments of specific ethnoracial minority groups (see, e.g., Lee, Blando, Mizelle, & Orozco, 2007; Smith, 2003; D. W. Sue & D. Sue, 2002; Vacc, DeVaney, & Brendel, 2003).

A problem, however, is that an emphasis on specific cultural competencies is perhaps unavoidably associated with psychological essentialism (Haslam, Rothschild, & Ernst, 2000). Psychological essentialism refers to processes of between-group categorization that presume "that these social distinctions have deeply rooted biological underpinnings, that they are historically invariant and culturally universal, or that their boundaries are sharp and not susceptible to sociocultural shaping" (2000, p. 114). As applied to ethnoracial diversity, then, such cognitive processes result in simplistic and stereotypical attributions of cultural difference. In the context of multicultural diversity more broadly, cultural essentialism can be seen to simplistically accentuate the injuries of race (Hollinger, 2005), reduce complex cultural processes to reified within-group traits (Brightman, 1995), presume greater between-group than within-group differences (Lakes et al., 2006), and prioritize professional protection from racism over cross-cultural understanding (Harlem, 2002). Some have even proposed that this approach to cultural competence is itself a form of "new racism" (Pon, 2009; see also S. Sue et al., 2009, for additional instances of similar critiques).

Although D. W. Sue and colleagues have acknowledged the dangers of cultural essentialism as well (e.g., by acknowledging the complexities of ethnoracial identity; D. W. Sue, 2001), they contend that such concerns do not ultimately undermine a focus on specific competencies. However, the diversity, complexity, and instability of culturally related processes and practices appear to have led several psychologists to advocate for "process-oriented models" of cultural competence (S. Sue et al., 2009), focusing on general processes of effective psychotherapy as incidentally applied to this or that ethnoracially diverse client (e.g., Lakes et al., 2006; S. Sue, 1998; S. Sue & Zane, 1987). Most notably, the American Psychological Association's (2003) official practice guidelines on multiculturalism—though inspired in large part by D. W. Sue's research—depart substantially from an enumeration of competencies, noting that "it is not necessary to develop an entirely new repertoire of psychological skills to practice in a culture-centered manner" (2003, p. 390). Instead these guidelines discuss the application of three processes that would in fact seem integral to quality psychotherapy with all persons: "focusing on the client within his or her cultural context, using culturally appropriate assessment tools, and having a broad repertoire of interventions" (2003, p. 390). In a similar vein, S. Sue (1998) has advocated for the cultural application of general processes: "scientific mindedness" and "dynamic sizing," with only "culture-specific expertise" remaining distinctive. Lakes et al. (2006) take this general approach further still, recommending "experience-grounded and process-oriented conceptualizations of culture that do not depend on group membership" (2006, p. 381). Instead of invoking essentialist notions of group differences, Lakes et al. call for engagement with "the client's social

world to identify what is at stake or what matters for the individual client'' (2006, p. 391) and emphasize the negotiation of a meaningful narrative (therapeutic emplotment) that is cocreated by practitioners and clients.

Although these process-oriented models of cultural competence may stem the tide of cultural essentialism, they also may come at the cost of the ability to identify any culturally distinctive tactics or strategies at all. As a result, cultural competence may become simply clinical competence because all psychotherapy—regardless of any targeted domains of difference among clients—requires professional nuance and sophistication for traversing the nomothetic–idiographic bridge, inspiring faith that the therapist can help, and contextualizing presenting problems within a client's distinctive life world (see APA Presidential Task Force on Evidence-Based Practice, 2006). Despite the limited evidence that specific cultural competence is more effective in some cases than general clinical competence (Constantine, 2002; Fuertes et al., 2006; S. Sue et al., 2009), it is clear that conceptualizations of cultural competence in psychology are pulled in opposite directions: toward specific cultural competencies on one hand and general clinical competence on the other. The question thus becomes whether there are tenable conceptual prospects for a form of cultural competence that lies somewhere between an indefensible cultural essentialism that stereotypes diverse clients and a generic clinical competence that in practice omits adequate attention to the profound implications of cultural difference.

Culturally competent therapists versus culturally constituted therapies

A commonly cited cultural competency is awareness of personal and institutional biases, as well as the role of sociopolitical influences and power dynamics (e.g., D. W. Sue, 2001). As part of this recognition, multicultural professional psychologists commonly point out that psychotherapy is itself European in cultural origin. For example, APA's (2003) multiculturalism guidelines state, ''The traditional Eurocentric therapeutic and interventions models in which most therapists have been trained are based on and designed to meet the needs of a small proportion of the population (White, male, and middle-class persons)'' (2003, p. 390). However, in spite of this acknowledgement, multicultural professional psychologists have been primarily invested not in radical reformulations of helping interventions but instead in engendering trusting responses from culturally diverse clients so that these clients too might reap the presumed salutary benefits of these psychotherapeutic interventions. This investment is clear in the case of the APA guidelines, which—in spite of asserting that Eurocentric models may be ineffective or even harmful to many people—devote their recommendations to ''therapeutic settings where individual, family, and group psychotherapy interventions are likely to take place'' (2003, p. 390).

This pragmatic acceptance of traditional psychotherapy models may explain why cultural competence scholars have focused primarily on characteristics and processes that are predominantly embodied and employed by *psychotherapists* who necessarily endorse and promote an array of shared assumptions and values

through their professional work. What is largely missing, however, is crucial recognition that the modern *psychotherapies* are cultural tools or artifacts that preserve in enduring fashion the semiotic signatures of their sociohistorical contexts of origin. Mainstream psychotherapy—a particular form of psychic healing that gives primacy to therapeutic expression (i.e., psychologically minded self-referential talk)—is based on a western cultural concept of the self as individualistic, rationalistic, monological, univocal, and egocentric (Cushman, 1995; Kirmayer, 2007; Taylor, 1992). Thus, to participate in psychotherapy at all is to embrace the ''talking cure'' in service to personal transformation.

Professional awareness of the cultural trappings of conventional psychotherapy approaches and techniques would seem especially pertinent in recent debates concerning evidence-based practice, owing to increasing standardization through the dissemination and implementation of such treatments. However, perhaps paradoxically, a commitment to preserving the integrity of mainstream (western) psychotherapy appears to underlie both the evidence-based practice (EBP) and multicultural movements within professional psychology. Specifically, proponents of EBP typically endorse the widespread proliferation of empirically supported treatments (ESTs)—integrated suites of therapeutic techniques vetted in randomized clinical trials for amelioration of targeted psychiatric disorders—and/or tout the general effectiveness of (Eurocentric) psychotherapy through research on common factors such as the therapeutic alliance (APA Presidential Task Force on Evidence-Based Practice, 2006). Similarly, multicultural psychologists typically harbor optimistic faith in the efficacy and utility of psychotherapy for the culturally diverse, and therefore generally advocate for the tailoring of established approaches and techniques so as to render them culturally palatable to a broader swath of the diverse national population. This optimism may be reflected in increasing advocacy for culturally adapted ESTs (e.g., Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Bernal & Scharrón-del-Rio, 2001; Hall, 2001; Whaley & Davis, 2007) or for common factors harnessed by culturally competent therapists (e.g., Atkinson, Bui, & Mori, 2001).

Although these adaptations may improve the cultural sensitivity of treatments, the failure to radically rethink the ideals of Eurocentric psychotherapy may limit these adaptations to relatively superficial or cosmetic alterations, in terms of the packaging and presentation of otherwise conventional counseling interventions. As a result, core features of conventional interventions are left completely intact. For example, Hays' (2009) ''ten steps'' for infusing cultural competence into cognitive–behavioral therapy (CBT) intentionally retain CBT's theoretical assumptions and basic procedures. Thus, for Hays, CBT's acknowledged individualism is a problem only for a ''less experienced therapist'' who neglects ''environmental interventions'' (2009, p. 356)—here, the onus for adaptation is on the therapist, not the therapy. Adaptation efforts might also be directed toward improving treatment accessibility, but not the treatments themselves. Consider, for example, some of S. Sue's (1998) recommendations for delivering ''ethnic-specific services'': ''providing flexible hours... placing treatment facilities in ethnic communities... employing

bicultural-bilingual staff... [and] serving tea rather than coffee to Chinese clients'' (1998, p. 442).

In order for this convergence of EBP and multiculturalism to occur, proponents of each side have made concessions, however unconscious, that serve to retain the status quo of conventional treatment for widespread dissemination. For example, EBP proponents have incorporated ''patient variables'' pertaining to race, ethnicity, and culture (APA Presidential Task Force on Evidence-Based Practice, 2006). For their part, multiculturalism proponents have conceded that ''cultural'' phenomena would be largely delimited to matters of packaging and presentation to the culturally diverse. But missing from both of these approaches—despite superficial acknowledgment by multicultural psychologists—is a substantive analysis and critique of psychotherapeutic interventions themselves taken as cultural constructs from surface to core and all the way through.

From cultural competence to cultural commensurability

In contrast to this unlikely convergence, we wish to propose an alternative. Rather than merely attending to the cultural competence of the psychotherapy practitioner involved in treating the culturally different, critical appraisal of the status of psychotherapeutic interventions as cultural artifacts in their own right is in order. Such analysis, we believe, will afford a more sophisticated and meaningful account of cultural commensurability between available forms of psychological intervention and the treatment needs of culturally diverse populations. For the remainder of this article, we explore this alternative frame in the context of innovative, locally controlled treatment programs in indigenous community settings. After providing a brief overview of these contexts, we discuss two approaches to intervention that have been developed by and for Native communities. In doing so, our goal is to draw attention to a continuum of cultural commensurability reflecting the therapeutic attributes of the interventions themselves. Such a reframing of cultural competence has relevance not only for indigenous mental health treatment, but for contemporary (re)conceptualizations and applications for counseling the culturally diverse within a broad array of community treatment settings.

Indigenous treatment settings

Though many Native communities and individuals experience disproportionately high rates of interpersonal distress, trauma-related pathologies, and substance abuse problems, professional psychotherapeutic interventions are commonly dismissed as ineffective or irrelevant (Gone & Alcántara, 2007). In one early study, 55% of American Indian clients failed to return for their second psychotherapy appointments, the highest dropout rate of any ethnoracial population in the study (S. Sue, Allen, & Conaway, 1978). More recently, American Indians with a variety of psychiatric problems have been shown to prefer culturally ''traditional'' services rather than formal medical services (Walls, Johnson, Whitbeck, & Hoyt, 2006), and

are as likely or more likely to consult traditional healers for help in comparison to mental health professionals (Beals et al., 2005).

Although the reasons for the reluctance of many American Indians to participate in mental health services have not been well studied, a consensus within Native communities has frequently coalesced around one prevalent explanation: culture. Knowledgeable individuals in tribal communities have routinely identified conventional treatment services as culturally discordant and therefore experientially alienating for many distressed Native people who are otherwise recognized as good candidates for truly appropriate helping services (Gone, 2007). This explanation makes sense in light of the divergences between the assumptions that structure and organize the modern psychotherapies and the assumptions that structure and organize selfhood and social interaction in many contemporary Native communities (Gone, 2007, 2010).

For example, contrary to western norms surrounding self-expression, many indigenous communities proscribe expressive talk outside intimate circles precisely because Native self and personhood are frequently configured within an ethos of personal autonomy, family reputation, and lifelong social ties (Basso, 1990; Darnell, 1981, 1991). Indeed, the protection and preservation of personal autonomy within a small-knit community can be seen to structure social interaction quite profoundly in these settings (giving rise, for example, to reticence, reserve, and noninterference) in ways that potentially confound the familiar individualism–collectivism dichotomy in psychology. Other cultural differences pertain to the linguistic underpinnings of mind and emotion that together comprise a distinctive ethnotheory of the person (Junker, 2003; Junker & Blacksmith, 2006), structures of local knowledge that center on percepts (rather than concepts) embedded in action (Preston, 1982), intricacies of social relations with other-than-human persons such as spirit helpers and animals who are hunted for food (Brightman, 2003), and conceptions of health and associated healing practices that construe well-being in much more comprehensive and holistic terms (Adelson, 2000; Morse, Young, & Swartz, 1991; Young, Ingram, & Swartz, 1989).

Owing to the histories of colonization in the United States and Canada, these cultural divergences do not represent merely neutral preferential alternatives for these communities. Instead, culture has become the battleground for ideological engagements wherein indigenous peoples have long been dominated by more recently arrived European settlers (Gone, 2008a). In recent decades, as a result of the Civil Rights, Red Pride, and multiculturalist movements, the tide has turned such that (limited) indigenous self-determination has become an acceptable alternative (Deloria & Lytle, 1984). One consequence of these movements has been greater recognition among professional psychologists—including a growing number of Native psychologists—of the need for culturally competent treatment, as well as indigenous healing practices, for indigenous clients. However, similar to the cultural competence movement generally, there has been a predominant focus on improving the cultural competence of therapists in order to deliver relatively established psychotherapeutic packages in a more welcoming and credible fashion

(see, e.g., Barnard, 2007; Jackson, Schmutzer, Wenzel, & Tyler, 2006; Limb & Hodge, 2008; Lomay & Hinkebein, 2006; Rayle, Chee, & Sand, 2006; Venner, Feldstein, & Tafoya, 2008; Weaver, 2004).

Developing indigenous treatments

At the same time, Native self-determination has led to greater indigenous community control of mental health treatment programs and resources (McFarland, Gabriel, Bigelow, & Walker, 2006) and widespread indigenous commitments to cultural reclamation and revitalization (Nagel, 1996). Not surprisingly, then, treatment programs and services that are administered by and for indigenous communities regularly seek to integrate Native culture and tradition into therapeutic settings and activities as a means for (a) providing treatment in a culturally tailored and compelling manner, and (b) redressing the legacy of colonization by affirming robust indigenous identities, institutions, and practices.

These integrative community-based treatment efforts provide an opportunity for reconsidering cultural competence beyond the characteristics of individual therapists, while also distinguishing these treatments from generalist approaches. Because of the prevalence and diversity of these efforts, empirical exploration of Native projects to integrate mainstream and traditional therapeutic approaches affords conceptual insight through the placement of such integration efforts along a continuum of cultural commensurability. One end of the continuum—global psychotherapeutic interventions—is anchored by any given mainstream treatment approach that might be offered in suburban clinics to middle-class citizens in many places throughout the "developed" world. The other end—indigenous healing traditions—is anchored by identifiable indigenous medical or "doctoring" practices that endure in relatively few places in modern times owing to the extensive impact of colonization. We suspect that the vast majority of mental health interventions administered by Native communities is situated between these two anchor points.

We briefly discuss two Native community-based treatment programs for which the second author has recently been involved in research partnerships (Gone, 2008b, 2009, 2011). These intervention programs emerged from deliberate and self-conscious indigenous efforts to deploy cultural knowledge and resources in the development of creative therapeutic alternatives. Thus, they extend well beyond surface notions of cultural competence and the familiar delivery of mental health services. As we demonstrate, these treatments appear to fall at different places along the continuum of cultural commensurability—the first seems relatively closer to the indigenous end and the second seems relatively closer to the global end. We point out this distinction not to suggest that one treatment is better than the other; rather, the situating of the two approaches between either extreme draws attention to the continuum as a way of thinking critically about culture and treatment in the context of an alternative terrain that avoids problems of untenable essentialism and inattentive generalism.

Case 1: Cultural immersion survival camp

The first case is the implementation and evaluation of a cultural immersion survival camp—currently in an early stage of development—as an alternative to inpatient substance abuse treatment on the Blackfeet Indian reservation in Montana (Gone & Calf Looking, 2011). The motivation for the survival camp is to craft a substance abuse intervention for community members that emphasizes Blackfeet cultural tradition much more heavily than global psychotherapeutic approaches to addiction problems. Thus, one goal of the project is to investigate what we term the ''culture-as-treatment'' hypothesis for reducing substance abuse problems for American Indians referred for residential treatment (cf. Brady, 1995). In contrast to the standard Minnesota Model residential treatment program presently administered by the Blackfeet Nation, the culture-as-treatment hypothesis proposes that a postcolonial return to indigenous cultural orientations and practices may itself be sufficient for effecting recovery from substance abuse problems for many Native Americans. Thus, this project will involve the development, piloting, assessment, and refinement of a summer cultural immersion camp as a radically innovative ''traditional'' alternative to standard residential treatment.

Based on current plans, the Blackfeet survival camp appears to be closer to the indigenous healing tradition end of the cultural commensurability continuum. A distinctive feature of the program will be socialization into a local, vibrant, and abstinent social network based neither on substance abuse nor recovery per se—a pathology-oriented identity that some American Indians resent—but instead on Blackfeet cultural reclamation and revitalization. As a result, client involvement in this network—involvement that is incompatible with substance use—is expected to carry forward well beyond the intervention proper. As currently conceived, this camp will consist of clients and staff residing in gender segregated tepees pitched well away from settled areas of the reservation for the duration of the 30-day treatment cycle. Camp life will involve ''living off the land'' while participating in a variety of associated Blackfeet traditional activities. Such activities are likely to include food procurement and preparation, camp maintenance, equestrian skills, cultural instruction, language preservation, traditional crafts, and ceremonial orientation and participation. Moreover, one important through line of camp activity—for those who so choose—will be the seminal opportunity to craft an individual ceremonial pipe for personal prayer under careful ritual mentorship.

Of course, the question still remains as to whether the survival camp will be a successful treatment for substance abuse problems—and, of course, the specific criteria for assessing success will be culturally grounded. However, in the context of multicultural professionals' efforts to grapple with the demands of evidence-based practice, there are several reasons why such a culture-as-treatment approach may be deserving of trial implementation and empirical evaluation. First, the scientific literature attests to the potential therapeutic benefits of cultural tradition when considering the life experience of many Native Americans who have recovered from substance abuse problems (Spicer, 2001; Torres Stone, Whitbeck, Chen,

Johnson, & Olson, 2006). Similarly, the metaphorical return to the ''Red Road'' (i.e., newfound participation in traditional activities and practices) has often been associated with sobriety (Mohatt et al., 2004; Spicer, 2001). Moreover, beyond post hoc attributions of the importance of traditional activities and practices for achieving sobriety, Native Americans routinely offer plausible explanations for the therapeutic benefits of indigenous cultural participation. These include spiritual revitalizations that result from indigenous ceremonial participation, interpersonal reorientations that yield new and renewed relationships in support of sobriety, and psychological transformations that alter personal identity, motivation, and purpose in service to positive lifestyle change. Thus, to the degree that a return to Blackfeet tradition might reorganize the existential, relational, and intrapersonal domains for Native clients, recovery from substance abuse seems a plausible outcome.

Case 2: A First Nations healing lodge

The second case is an ethnographic exploration of a Manitoba First Nations community's efforts to create ''an integrated and holistic therapeutic approach to healing and wellness for individuals, families and the community utilizing western and aboriginal practices'' (as quoted in Gone, 2011, p. 191) in their local ''Healing Lodge'' (see Gone, 2008b, 2009, for more details). Employing 25 northern Algonquian staff members, this nationally accredited treatment center provided inpatient, outpatient, and referral services for substance abusing Aboriginal persons throughout Canada. Healing in this setting was characterized as ''the ongoing process of positive self-transformation—fueled by... finding one's purpose as an Aboriginal person—that ultimately reorient[s] fragile and often damaged selves toward a more meaningful and compelling engagement in the world'' (Gone, 2011, p. 196).

The second author spent 7 weeks of residence at the lodge in order to provide an ethnographic description of its professional programming—with special attention to key facets of the therapeutic discourse among staff and clients—as well as critical assessment of the prospects and predicaments of integrating Aboriginal healing practices into a western-style, federally-funded, health care institution. Therapeutic efforts of the counseling staff comprised a variety of western and Aboriginal approaches and techniques (Gone, 2008b, 2011). Western therapeutic modalities included the Twelve Steps of Alcoholics Anonymous, grief exercises, anger discharge, inner child work, genogram mapping, neurolinguistic programming, and other ''complementary and alternative'' therapeutic techniques. The appeal of such techniques inhered in their association with spiritual principles and practices that were sometimes appropriated with reference to Aboriginal tradition. Aboriginal therapeutic modalities included smudging, talking circles, tobacco offerings, pipe ceremonies, sweat lodge rites, and fasting camps.

Based on this description, as well as more general familiarity with lodge activities, one might suspect that the lodge's treatment approach would be placed quite close to the traditional indigenous treatment end of the cultural commensurability continuum. However, the cultural commensurability of this treatment approach

was further inflected by central but tacit aspects of local therapeutic discourse. Specifically, Gone's (2011) analysis reveals that some aspects of the lodge's therapeutic approach seem to be drawn from fairly popular tenets of global therapy culture. Staff and clients made routine reference to the "carrying" of painful "burdens" from a traumatic past, the excavation ("digging") of deeply buried personal pain in the effort to purge its toxic effects, the "release" of emotional "pressure" through cathartic talk, and the commitment to "looking at" and "working on" oneself as a therapeutic project (2011, pp. 195–196). This westernized discourse was implicitly evident, despite the therapeutic approach being explicitly anchored and structured by the pan-Aboriginal concept of the medicine wheel (with a culturally resonant emphasis on holism and cyclical life movement). Thus, the hybrid form of therapy crafted and promoted at the lodge probably requires location on the cultural commensurability continuum a bit more toward the global psychotherapy endpoint than one might have initially supposed.

This analysis may be especially relevant for the proponents of cultural competence, in that (a) even an intentionally crafted traditional approach to healing retained identifiable aspects of global psychotherapeutic interventions, and (b) such aspects became apparent through an ethnographic examination of both overt and tacit aspects of therapeutic discourse. Only by delving beneath general recommendations and guidelines for cultural competence—the cover story of culturally sensitive therapy—can one appraise the cultural commensurability of a given treatment in actual practice. Thus, the predominant concern with training culturally competent therapists may neglect the extent to which even multiculturalist therapies are themselves situated in a broader context of Euro-American influence. This predicament is not necessarily negative, but it raises further questions about the role of culture in treatment: How much culture is enough? What exactly does it mean to speak of a minority culture in juxtaposition to the dominant one? And what implications does a blending of cultural practices harbor for the increasing number of individuals seeking "traditional" cultural reclamation and revitalization? (see Gone, 2010).

Concluding reflections

Although clear answers to these questions lie beyond the scope of this article, we are fairly confident that the cultural competence movement sidesteps them, whether by retaining an untenable essentialism with regard to group cultural affiliation or by evacuating cultural considerations altogether through the promotion of generic clinical techniques. In contrast, as we have demonstrated in the described case examples, an attention to the cultural commensurability of the interventions themselves complicates matters considerably. Indigenous communities have long negotiated the ideological implications of "culture" and thus remain poised to deconstruct forms of psychotherapeutic intervention as cultural artifacts that carry with them substantial traces of their nonindigenous contexts of origin. Rather than endorsing breezy notions of cultural competence, these

community-based efforts suggest a more fundamental project of agentic indigenous cultural reconstruction in, through, and for therapeutic projects that aim for commensurability with contemporary commitments to postcolonial cultural reclamation and revitalization. In doing so, they illuminate a continuum of cultural commensurability that accentuates cultural hybridity in the formulation of innovative mental health interventions qua interventions. We recognize that many questions remain about the proper role of professional psychologists in these endeavors. These questions are beyond the scope of this article, but clearly a commitment to culturally commensurate treatments would require very different ways of conceptualizing culture and community engagement within professional psychology relative to current training regimens in the United States (Gone, 2004).

We have discussed extant notions of cultural competence in professional psychology with specific attention to the dominant ''kind-of-person'' models that emphasize proposed characteristics or attributes of culturally competent psychotherapists. Even among psychologists, this approach to cultural competence is controversial owing to professional misgivings concerning its essentialist assumptions. Unfortunately, alternative ''process-oriented'' models of cultural competence emphasize such generic aspects of therapeutic interaction that they remain in danger of stifling substantive attention to culture in the name of basic clinical competence. For cultural competence to persist as a meaningful construct, an alternative approach that avoids both essentialism and generalism must be recovered. In this regard, we have proposed that one means to capturing this alternative is to focus less on psychotherapists as culturally sensitized persons and more on psychotherapeutic interventions as culturally constituted artifacts. In this regard, two examples from North American indigenous communities have afforded insight about the possibility for local, agentic, and intentional deconstructions and reconstructions of mental health interventions in a culturally hybrid fashion.

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