

AN ABSTRACT OF THE THESIS OF

J. Olivia Drumm for the Master of Science

in Art Therapy Counseling presented on July 9, 2013

Title: Incorporating Art Therapy as part of Behavioral Health Services offered at an Indian Health Services (IHS) Facility: Interviews from the Navajo Reservation

Abstract approved: \_\_\_\_\_

The purpose of this qualitative study was to better understand how an art therapist would be perceived and utilized at an Indian Health Services (IHS) facility on the Navajo Reservation. Specific focus was on how an art therapist fits into the treatment team, the perceptions of each behavioral health facilitator about art therapy, and their evaluations regarding the desirability of using art therapy with Native Americans. The hypothesis was that art therapy is an appealing and culturally appropriate form of therapy for Native Americans. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing.

A secondary hypothesis developed the research. Cultural competence of the therapeutic service providers in relation to the population being served (i.e. understanding of nuances within the culture such as spirituality, taboos, political history, indigenous/traditional beliefs, etc.), as well as one's personal background (i.e. ethnicity, spiritual affiliation, relationship to population, etc.) has relevance in patient outcomes and staff cohesion.

The research was conducted primarily with participants volunteering from the behavioral health treatment staff of the Chinle Comprehensive Health Care Facility (CCHCF) in Chinle, AZ. Eleven CCHCF Behavioral Health staff, and two school counselors with whom the CCHCF Director worked at Chinle, AZ public schools volunteered as participants for in-person, open-ended interviews. The interviews covered topics such as the exploration of the participant's profession, cultural perceptions, and reflections on art therapy as a form of treatment. During the separate individual interviews, the scribble drawing assessment was administered, providing the participants with an opportunity to experience an art therapy directive.

Interviews were documented through notes and a digital recording device after an informed consent document was provided and signed. Data was collected through field research using phenomenological methods of interviewing and participant observations, including progressive focusing.

INCORPORATING ART THERAPY AS PART OF BEHAVIORAL HEALTH  
SERVICES OFFERED AT AN INDIAN HEALTH SERVICES (IHS) FACILITY:  
INTERVIEWS FROM THE NAVAJO RESERVATION

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A Thesis

Presented to the Department of Counselor Education

EMPORIA STATE UNIVERSITY

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In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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by

J. Olivia Drumm

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Approved by the Department Chair

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Education

## ACKNOWLEDGMENTS

I would like to thank everyone who helped me on this journey. I have an immense appreciation for the challenges, celebrations, and unexpected twists.

To a new world just opened and transformation of the senses and soul!

Ode to blessings!

Ode to the process!

Ode to life!

For Zia.

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Incorporating art therapy as part of behavioral health services offered at an Indian Health Services (IHS) facility: Interviews from the Navajo Reservation

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# CHAPTER 1

## INTRODUCTION

Art, in its various expressions such as song, dance, ritual, drama, literature, and sculpture exists in every ethnic group on the planet Earth. Art is valued as a necessary component of being alive. Since antiquity, the arts have been recognized around the world (ancient Egypt, Europe, Africa, Chinese, Greek, Hebrew, India, the Americas, etc.) as a form of communication and as a means to prevent and help treat what we currently refer to as mental disorders (Henderson & Gladding, 1998).

The Greek founders of western medicine maintained a perspective of healing akin to indigenous or what many cultures refer to in daily language as ‘traditional’ healers today. Imagination was inseparable from health. Images were the primal and core language of humanity. Nonetheless, western medicine and psychology have evolved with values and principles of cause and effect, a need for scientific evidence, beliefs in a universal truth (which tends to be Eurocentric), and an orientation to the individual (Henderson & Gladding, 1998).

Though valuable in many ways, these perspectives often discount the benefits of treatment systems not validated by quantitative research, resulting in the isolation of non-western individuals from the advantages of behavioral/mental health treatment. Essentially, western medicine is supported by a medical model not universally shared by all cultures. Most existing ethnicities have practiced indigenous healing methods for thousands of years; yet these methods are not recognized as legitimate means of healing in western medicine and psychology due to lack of research and quantitative evidence (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). Having a more complete integration of indigenous healing methods and alternative approaches to

behavioral/mental health, including art therapy, with the philosophy and ideals of current mainstream behavioral/mental health public policy and implementation, is necessary for more comprehensive and inclusive behavioral/mental health services in the United States.

## **LITERATURE REVIEW**

The purpose of this study was to evaluate the desirability of using art therapy with Native Americans as a treatment method in conjunction with or as an alternative to The American Psychiatric Association (APA<sub>1</sub>, 2012) and The American Psychological Association (APA<sub>2</sub>, 2012) psychological constructs and traditional healing methods. A brief history of the impact of European colonization of Native Americans was presented in the literature review as well as an introduction to the origins of the American Psychiatric Association, American Psychological Association, and the field of art therapy. A definition of traditional/indigenous healing and examples explaining why alternatives to APA<sub>1</sub> and APA<sub>2</sub> psychological constructs or treatment methods would be beneficial for populations that still subscribe to traditional/indigenous beliefs and methods of healing are provided. Finally, the ethics of how one would use art therapy with Native Americans and past approaches of art therapists working with Native Americans, was examined. The Literature Review ends with a brief account of events in the life of the researcher that preceded the thesis research, informing the direction it would take.

### **Native Americans**

**European colonization.** An understanding of the history and effects of European colonization of North America is necessary when addressing current public health dynamics in Indian Country. Native Americans helped European settlers survive in the

new land; sometimes tribes aligned with the Europeans for the benefits of trade and increases in military power to stave off enemy tribes (O' Meara & West, 1996; Riley, 1993; Thornton, 1998). Peaceful and harmonious exchanges existed between cultures, but were overshadowed by the dominant mood among the Europeans in power, which was captured in the 19<sup>th</sup> century with the phrase Manifest Destiny or more specifically Indian Removal. Manifest Destiny was a convenient belief for settlers allowing them to acquire native land with the notion they were divinely chosen (by their Christian god) to acquire land and populate the world. The natives were regarded in biblical terms as people whose conquering was ordained by the divine (O' Meara & West, 1996; Riley, 1993; Thornton, 1998). With the rise in population and increasing strength of the colonies, interaction with Native Americans were grounded in policies of assimilation, cultural genocide, and ultimately annihilation (Grimberg, Makepeace, Zwonitzer, & Erye, 2009). At the end of the 18<sup>th</sup> century, the Native American population was only ten percent of its size prior to colonization (Oswalt as cited in Garrett & Pichette, 2000).

The United States government entered into over 300 treaties with different Native American tribes, and broke every one of them (Riley, 1993). Treaties between groups defined terms of peace and friendship, establishing tribal sovereignty, tribal lands, and boundaries (Deloria, 1969). One of the oldest treaties between the United States and a Native American tribe dates back to the Pickering Treaty of 1794 between the Seneca tribe of the Iroquois Nation and the United States of America. Part of the terms of the Pickering Treaty, and many other treaties between the United States government and Native tribes, was that the government had no right to claim land both parties agreed belonged to the tribe. Nevertheless, in the 1960s, the United States government built a

dam on the Seneca reservation without seeking permission from the Seneca Tribe (Deloria, 1969).

Many treaties were broken through force. Others were broken through outright disregard of the treaty or by legislative loopholes. For example, the Dawes Allotment Act of 1887 caused the dissolution of 90% of established reservations and resulted in the removal of 75% of Native Americans from the Native American census (Turner, 2002).

Senator Henry Dawes pushed for the establishment of the act (Toensing, 2012) with the belief that Native Americans needed to be “civilized.” Breaking up tribes who had lived communally, who once had shared land with the guarantee that no tribal member went homeless, not only resulted in land loss, but had the desired effect of divide-and-conquer, and the break-up of once powerful tribes into individual homesteads. For many tribes, the Dawes Act marked the end of their identities as distinct tribes. Without the strength of numbers and proximity of communal living, tribal traditions, culture, and a way of life were almost destroyed (Toensing, 2012).

Not a single Native American tribe was able to escape the effects of colonialism (Garrett & Pichette, 2000). Many were relocated hundreds of miles from their tribal lands. The “Trail of Tears” took place in the 1830s and is an example of the removal of Cherokee, Muscogee-Creek, Chickasaw, Choctaw, and other tribes from the east to what is now Oklahoma (Garrett & Pichette, 2000). Thousands died along the way. The United States military treated Native Americans like cattle, rounding them up and herding them to government sanctioned land areas called reservations. Colonists brought new diseases to which the Native Americans had not been exposed, had neither resistance nor knowledge of a cure. The colonists depleted wild game, and desecrated sacred sites that

were foundations of Native American spirituality. In addition, there were instances, such as the Sand Creek Massacre of 1864, where the United States military slaughtered entire villages of unarmed Native Americans (Thornton, 1998).

United States governmental policies of Native American assimilation, cultural genocide, and disregard of treaties continued into the 1900s and are present today. For example (Thornton, 1998; Turner, 2002), in the late 1800s the United States government began a policy of removing Native American children from their families and sending them to boarding schools, often hundreds of miles away, in an effort to “civilize” the tribes through the cultural assimilation of the children. The children were not allowed to speak their native language, and were required to speak only English. Their hair was cut and their cultural identity stripped. Frequently, many years would pass before the children would see their families again. The removal policy continued into the mid-1900s (Thornton, 1998). Native American children were not safe from United States government policies of removal until the 1978 Indian Child Welfare Act was enacted (Turner, 2002).

In the 1950s, the United States government urged Native Americans to relocate from rural areas and reservations to urban areas (Thornton, 1998). The motives for the relocation program were for further assimilation of Native Americans with wage labor and white middle class American values. The outcome of the 1950s relocations was greater dissolution of communities and families with some of the Native Americans staying in the cities, some returning home, and others travelled back and forth (Thornton, 1998).

During the 1960s and 1970s, the United States government, through various governmental agencies including Indian Health Service (IHS), sterilized more than 3,000 Native American women between the ages of 15 and 44 (Lawrence, 2000). The sterilization frequently occurred without the women's consent, with uninformed consent, or with the deception that another type of surgery, such as an appendectomy, was needed. Many Native Americans believe IHS was responsible for the sterilization of at least 25% of the women (Lawrence, 2000).

Religion or Spirituality is inseparable from culture in the everyday life of traditional Native Americans. Until 1978, when Congress passed The American Indian Religious Freedom Act (AIRFA), the United States government forcibly suppressed the practice of Native American religion (Thornton, 1998). The United States government found Native American religions threatening to United States sovereignty. The Ghost Dance taught and prophesied by Wovoka, a Paiute spiritual leader (Thornton, 1998), is an example of a Native American spiritual practice that evolved into a movement the United States government found threatening. The practice called for a return to traditional ways and promoted beliefs, such as wearing a ghost dance shirt that would allow warriors to walk into battle without fear of cavalry bullets. The Ghost Dance movement ended tragically at the hand of the United States seventh cavalry on December 29, 1890; the Wounded Knee massacre. Finally, after Congress passed the AIRFA, Native Americans were assured the right to actively participate in and practice their religions without federal or state government obstruction or repercussions (Thornton, 1998).

Native Americans are still battling the United States government. Mary and Carrie Dann of the Western Shoshone Tribe in Nevada have been in litigation and protest with

the United States government since 1972 (Gage & Gage, 2007). The United States Bureau of Land Management (BLM) fined the Danns for not obtaining grazing permits and paying grazing fees for livestock on their ranch in Crescent Valley, Nevada. Conversely, the 1868 Treaty of Ruby Valley recognized the Dann's ranch as within Shoshone territory, giving the Shoshone tribe jurisdiction. Over time, the United States government through different acts of legislation (Gage & Gage, 2007) confiscated much of the land in the Treaty of Ruby Valley.

In 1979, the United States government tried to buy the remaining land from the Ruby Valley Treaty for 26 million dollars (Gage & Gage, 2007). Eighty percent of the Shoshone tribe voted against the sale, yet the United States government ignored the Shoshone and forcibly bought the land through the United States Department of Interior (Gage & Gage, 2007).

In 1993, the Danns' case was presented to the Inter-American Commission of Human Rights (IACHR); the Commission declared the United States Government in violation of international human rights law (Gage & Gage, 2007). The 2007 documentary about the Danns, titled *American Outrage*, reported that the United Nations Committee on the Elimination of All Forms of Racial Discrimination (CERD) issued a decision in March of 2006 through its Early Warning and Urgent Action Procedures advising the United States government to "freeze," "desist from," and "stop" actions being taken or threatened to be taken against the Western Shoshone people. The United States government has ignored and continues to ignore the Treaty of Ruby Valley, the rights of the Danns, The Inter-American Commission of Human Rights, and the United Nations

Committee on the Elimination of All Forms of Racial Discrimination (Gage & Gage, 2007).

**Navajo nation/ Diné history.** The research for the thesis took place on the Navajo Reservation and nearby border towns. A brief account of Native American history post-European ‘discovery’ was included in the literature review. Many different tribes were referenced, which is necessary for a more thorough understanding of cultural nuances and unity of philosophy and experience, which many refer to as Pan-Indianism(Thornton, 1987). Pan-Indianism developed in response to Federal policy, which grouped all tribes together under one categorization, Indian, with Federal organizations operating under titles such as Bureau of Indian Affairs, or Indian Health Services (Thornton, 1987). When working with a single tribe, such as the Diné or Navajo, it is necessary to learn about that particular tribe’s history, culture specific nuances, and symbolisms for a better understanding of historical trauma present and cultural context that should be considered while working in a therapeutic setting serving that tribe. The Navajo Nation is populated with more than 250,000 people, and covers over 27,000 square miles in the states of New Mexico, Arizona, and Utah. The land is often referred as Navajoland, or Diné Bikéyah, Home of the People (Davies, 1998; The Navajo Nation, 2012). The Navajo people often call themselves the Diné, the Earth Surface People, and refer to their language as Diné. The official government title is Navajo Nation. The Navajo Nation is the most populated Federally recognized Native American Tribe in the United States. A tribal government was established in 1923 to prevent further exploitation by the United States government and private companies, when oil was found on Navajo land (Davies, 1998; The Navajo Nation, 2012).



The Navajo Reservation is located in a high desert and mountainous terrain. The Navajos were nomadic for most of their existence. They blended different cultural traits and practices from the various tribes they encountered into their own way of life. Many archeologists and anthropologists (Acrey, 1996; Levy, 1998) view the Navajo to have originated from Asia, in what is now the region of Mongolia and Eastern Siberia. The Navajo ancestors were thought to have migrated through the Bering Strait southward from Alaska over 3,000 years ago. They belonged to a group of people in the Nadene language group, a relatively newer set of people thought to have taken part in the great migration to the Americas. The Navajo are categorized as being part of the sub-group the Athabascan (Acrey, 1996).

Traditional Navajo and academics often have an entirely different set of beliefs regarding Navajo origins (Levy, 1998 & Sandner, 1991). Traditionalists believe the Navajo are currently in their fifth world of creation or life. Each subsequent world was abandoned for a different one, a hope for a better-suited world, or due to destruction of a previous world. First Man and First Woman emerged into this current realm from a large female reed that touched the roof of the fourth world. The site of the emergence is located on the Navajo Reservation (M. Austin-Garrison, personal communication, Spring 2011; Levy, 1998; Sandner, 1991).

First Man created the hogan (an important dwelling for the Navajos) as a 'mini cosmos' or a structure representing the center of the universe (M. Austin-Garrison, personal communication, Spring 2011) it is a place for maintaining the sacred with many different symbolisms attached to the structural elements and with the layout of the design opening toward the east. Navajo territory was established with the creation of four sacred

mountains: Dibe Nitsaa, Sis Naajini, Tsoodzil, and Litso. These four mountains and two smaller mountains, Dzilna oodilii and Choolii, create a boundary that symbolically forms the layout of a hogan (M. Austin-Garrison, personal communication, Spring 2011).

Hogans can be seen throughout the Navajo Reservation. Many people still live in hogans or grew up in a hogan.

White Shell Woman (Changing Woman) was conceived by her mother Darkness and father Dawn (M. Austin-Garrison, personal communication, Spring 2011). Her conception and birth marks the beginning of the Blessing Way Cycle or Ceremony. Blessing Way (Hózhó jí) began at the place of emergence and tells the stories of Navajo creation, Holy People, and fosters peace and harmony or balance. The creation of sand paintings are part of the Blessing Way Ceremonies. Humans were created by White Shell Woman (Changing Woman) and the Sun. Changing Woman and the Holy People (M. Austin-Garrison, personal communication, Spring 2011; Levy, 1998; Sandner, 1991) created the Navajo.

Changing Woman and the sun conceive and she gives birth to the Hero Twins, Monster Slayer and Born of Water (M. Austin-Garrison, personal communication, Spring 2011; Levy, 1998; Sandner, 1991). The twins are famous for killing all of the monsters of the fourth world that inhabited the land of the Navajo. The Enemy Way (*Nidaa'*) Ceremony was created as a purification for the twins of all the violence they committed while eradicating the monsters (M. Austin-Garrison, personal communication, Spring 2011; Levy, 1998; Sandner, 1991).

Like most Native tribes' encounters with early European settlers, the Navajo's experience with 'whites' or biligaana, was rife with tension and tragedy. In fact, the term

‘Navajo’ comes from the Spanish in reference to their relations with and perceptions of the Diné and means murderers, thieves, raiders, robbers (Acrey, 1979 & Acrey, 1996). At one point Navajos were captured by the Spanish and made part of the slave trade. Missionaries took Navajo children, baptizing them into Christianity and did not return them to their families; instead they were told they were now part of a ‘Christian Family’ (Acrey, 1979 & Acrey, 1996).

In the 1700s, the Navajo fought with the Comanches and Utes in the North (Acrey, 1996). Taking advantage of the situation, the Spanish began settling on Navajo land. The Navajos turned their attention to the Spaniards and began fighting them off. Soon the Spaniards retaliated with support from the then governor of the territory. They killed all the Navajos in Canyon de Chelly and destroyed vast numbers of peach trees located there (Acrey, 1996).

During the 1800s, the enabling act was responsible for the division of Navajo land into checkerboard areas. Further demarcation was made to the Navajo land in the establishment of the Navajo Reservation. At this time in United States history, all tribes were designated wards of the Federal Government and became subject to rules governing the Bureau of Indian Affairs. Fighting continued between bands of Navajo, the Spaniards, and Mexicans as well as the United States Cavalry (Acrey, 1979).

In the summer of 1863, Kit Carson, an American frontiersman, member of the first New Mexico Cavalry, and “Indian Fighter” ordered the first group of Navajos removed from their land (Acrey, 1979). The Navajos were then marched on “The Long Walk” (Acrey, 1979) to the Bosque Redondo Reservation at Fort Sumner several hundred miles away. Orders were given to shoot anyone trying to escape on the walk. Many died.

The “Long Walk” was actually multiple walks by the Navajo in a three-year period. They were relocated to designated areas near and including Bosque Redondo Reservation. The earlier route became known as the Santa Fe route, as General Carleton ordered the troops to march the Navajo through the streets of Santa Fe to humiliate and demonstrate their control of the Navajo (Acrey, 1979).

The Bosque Redondo Reservation was inadequate in size to maintain a large group of people (Acrey, 1979). Basic supplies for survival were limited. In 1865, the state-operated Doolittle Committee was established to investigate the state of affairs at Bosque Redondo. Soon the Department of the Interior sent its own group, the Graves Committee. In 1867, the Department of the Interior took over the affairs at Bosque Redondo from the Department of War. In April of 1868, Manuelito, Barboncito and many other Navajo headmen went with agent Dodd to Washington, DC to meet with President Andrew Johnson and discuss the problems at the reservation. Finally, after several meetings and a prolonged investigation, Bosque Redondo was deemed a failure and in the summer of 1868 the Navajos were allowed to return home (Acrey, 1979).

Once oil, uranium, and other minerals were discovered on the newly demarcated Navajo land, the United States government set up the Navajo Tribal Council in 1923 (Acrey, 1979) to maximize exploitation of Navajos through mineral resource acquisition. After a time of prosperity among the Navajo, the United State government ordered a reduction of livestock, resulting in the slaughter of thousands of sheep and goats, a general waste of meat during the United States ‘Great Depression’, and end of Navajo prosperity (Acrey, 1979).

In the 1930s and 40s the Native American Church (NAC) became popular with Navajos after the Ute tribe at Towaoc and Oklahoma tribes visiting the Utes (Aberle, 1966), introduced it to them. NAC participants use peyote as their medicine, or agent of worship and transformation. Ceremonial songs are sung, prayers spoken in a meeting that lasts from nightfall to sunrise. During the 1950s, the NAC faced opposition and persecution in the form of raids and arrests by the Bureau of Indian Affairs (BIA) on the reservation (Aberle, 1966). Native American religious ceremonies were still viewed as threatening to the government and the use of an illegal substance as part of the ceremony added to the opposition.

After WWII, many Navajo children were taken by force or intimidation from their families and shipped to boarding schools across the country (Acrey, 1979). In the 1950s, the BIA took part in creating an educational system and built several boarding schools on the Navajo Reservation. The first college classes were offered on the Navajo reservation in 1969 (Acrey, 1979).

The effects of religious persecution, conflict with the US cavalry, abduction of children to boarding schools, reductions of livestock, mineral exploitation, and differences between Navajo traditional thought and academic perspective is still apparent today on the Navajo reservation. Family structure was forever altered when children were sent away. Many Navajo adults in their 40s and older have similar stories of separation from their families and can recall their time spent at boarding schools and their assimilation into “white society.” Racism is still quite strong in border towns between Navajos and biligaana. There is a general distrust on the reservation of non-Navajo, non-Native newcomers. Traditional ceremonies are protected from non-Natives and can be

difficult to witness, learn about, or participate in. There is division among Navajo who identify as traditional and Navajo who do not. People are still being affected by quarrels over mineral rights, as well as radiation contamination from uranium mining.

**Native American identity.** The United States Department of Interior Bureau of Indian Affairs (BIA) recognizes 564 tribes in the United States totaling about 1.9 million Native Americans, including Alaskan Natives (United States Department of the Interior, BIA, 2009). The BIA (2009) webpage stated, “the Bureau of Indian Affairs administers 220,000 tracts of trust land, representing 55 million surface acres and 55 million subsurface estate on behalf of 280,000 American Indians, Alaskan Native, and federally-recognized tribes” (Homepage, para. 1-2). According to the 2010 United States Census (2010):

5.2 million people in the United States identified as American Indian and Alaskan Native, either alone or in combination with one or more other races. Out of this total, 2.9 million people identified as American Indian and Alaska Native alone. Almost half of the American Indian and Alaska Native population, or 2.3 million people, reported being American Indian and Alaska Native in combination with one or more other races. The American Indian and Alaska Native in combination population experienced rapid growth, increasing by 39 percent since 2000.

(Introduction, para. 1)

There is lack of uniformity in the methodology used to identify who qualifies as Native American. Each tribe has its own criteria for determining tribal membership. According to Thornton (1998) this criterion includes “language, residence, cultural

affiliation, recognition by a community, degree of “blood,” genealogical lines of descent, and self-identification” (p. 26). The BIA (Garrett & Pichette, 2000) defines a native person as one who is enrolled in a federally recognized tribe or who has a blood quantum of one-fourth Native American blood that is traceable through genealogical records. The United States Census Bureau allows people to self-identify as Native American (Garrett & Pichette, 2000).

Acculturation and United States government policies of cultural extermination account for much of the discrepancies in identifying who qualifies as Native American. Garrett and Pichette (2000) identified five levels of Native American acculturation:

1. *Traditional*. The individual may speak little English, thinks in the native language, and practices traditional tribal customs and methods of worship
2. *Marginal*. The individual may speak both languages but has lost touch with his or her cultural heritage and is not fully accepted in mainstream society.
3. *Bicultural*. The person is conversant with both sets of values and can communicate in a variety of contexts.
4. *Assimilated*. The individual embraces only the mainstream culture’s values, behaviors, and expectations.
5. *Pantraditional*. Although the individual has only been exposed to or adopted mainstream values, he or she has made a conscious effort to return to the “old ways.” (para. 28)

Despite major discrepancies, a clear understanding of the intricacies contributing to Native American identity is vital in matters concerning Native Americans.

**Native Americans and behavioral/mental health.** Native Americans consistently rank as one of the most impoverished ethnic populations in the United States. Rates of alcoholism are 550% higher than the general population, suicide rates are 70% higher, and homicides 100% higher (United States Department of Health and Human Services, IHS, 2009). From 1992-96 Native Americans age 12 and older experienced violent victimizations, including sexual assault and rape, at a rate twice the national average (United States Department of Justice, BJS, 1999). Native American children and adolescents are “at higher risk for mental disorders, depression, substance abuse, dropping out of school, delinquency, suicide, and homicide (in particular through vehicular accidents) than any other ethnic minority group in the general United States population” (Nelson & Manson as cited in Running Wolf, Soler, Manteuffel, Sondheimer, Santiago, & Erickson, 2002, p. 2).

Brave Heart and DeBruyn (1998) suggested that many of the social problems Native Americans face are rooted in historical unresolved grief or historical trauma. The Takini Historical Trauma webpage (2012), a contact point for Dr. Brave Heart and a source of information on historical trauma workshops, defined historical trauma as “cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma” (para. 2). Symptoms of Post Traumatic Stress Disorder (PTSD) and historical trauma including “unsettled trauma, depression, high mortality, increase of alcohol abuse, child abuse and domestic violence” (Takini Historical Trauma Homepage, 2012, para. 7) have disproportionate rates among Native Americans compared to non-Native Americans in the United States. Brave Heart & DeBruyn (1998) also compared the tragedies suffered by Native Americans from



European colonization and the policies of the United States government with what the Jewish people experienced during the holocaust of WWII. Native Americans, they felt, experienced their own holocaust at the hands of the United States government.

Despite these past atrocities, Native Americans rely on various United States governmental departments for behavioral/mental health treatment. The Indian Health Service (IHS) is the largest agency provider of behavioral/mental health services. The Bureau of Indian Affairs is also a large contributor to Native American behavioral/mental health services (LaFramboise, 1988). Tragically, both the IHS and the BIA have contributed to past historical trauma for Native Americans. For example, the IHS participated in the sterilization of over 3,000 Native American women in the 1960s and 70s (Lawrence, 2000), and from the BIA, through the child removal act, when thousands of Native American children were forcibly sent to boarding schools (Thornton, 1998). Native American distrust of behavioral/mental health providers and treatment methods is understandable; their feelings deserve respect and acknowledgement in the context of previous atrocities and current societal oppression (Dana, 1993; Gage & Gage, 2007; Lawrence, 2000).

The percentage of Native American clinicians and providers offering behavioral/mental health services in the United States is disproportionate to Native populations (LaFramboise, 1988). If a Native American were to seek behavioral/mental health treatment, it is likely a non-Native practitioner would see him or her. Furthermore, most university trained behavioral/mental health practitioners are educated in the Euro-American tradition, which emphasizes ego strength, individuality, and insight into the self. A common complaint by Native Americans is that western constructs for

behavioral/mental health treatment fail to understand, acknowledge, or integrate Native American values as part of psychological evaluations and treatment plans.

Acknowledgement of Native American culture is essential to achieve and maintain good behavioral/mental health. Native Americans embrace community as an integral component in the healing process; the traditional healer is the facilitator, who offers insight and acts as the conduit to the spirit realm (LaFramboise, 1988).

### **Contextual Critiques of the American Psychological and Psychiatric Associations**

The American Psychological and Psychiatric Associations are the dominant psychological organizations in the United States. Both were founded in the 1800s. They influence education, public behavioral/mental health facilities administration, policies of the National Institute for Mental Health, psychological constructs, academic writing style, theory, assessment, treatment, and diagnosis.

The American Psychiatric Association (APA<sub>1</sub>) traces its roots (American Psychiatric Association, 2012) to one of the signees of the Declaration of Independence and publisher of the first psychiatric textbook in the United States, Benjamin Rush, who was known as the “Father of American Psychiatry.” Because of the great number of psychiatric casualties in World War I, the APA<sub>1</sub> adopted the Statistical Manual for Hospitals (American Psychiatric Association, 2012) to use for disease classification and statistical reporting. In 1946, the APA<sub>1</sub> instituted the first set of mental health standards for psychiatric hospitals and outpatient clinics and in 1952 published the first edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The APA<sub>1</sub> currently has over 35,000 psychiatrists as members (American Psychiatric Association, 2012; American Psychological Association, 2012).

The American Psychological Association (APA<sub>2</sub>) began in 1832 with a group of young men interested in what they referred to as “the new psychology” (American Psychological Association, 2012, para. 2). This initial organization of 31 men has grown into a well-established association with more 148,000 members. World War II initiated a radical shift in philosophy and increase of membership in the APA<sub>2</sub>. At the time, “The GI Bill, the new Veterans Administration Clinical Psychology training program, and the creation of the National Institute of Mental Health contributed to increased interest in psychology” (American Psychological Association, 2012, para. 11). Fearing competition from other psychological associations, primarily due to the rising popularity of applied psychology, the APA<sub>2</sub> merged with many of their perceived competitors, diversifying the scope of the association’s concepts of psychology (American Psychological Association, 2012).

Despite the APA<sub>2</sub>’s diversity, APA<sub>2</sub> trained psychologists do not always treat clients from non-western cultures appropriately (Pedersen, Draguns, Lonner, & Trimble, 2008). The symptoms that bring a non-western client to therapy may be distorted and taken out of cultural context by Eurocentric assessments. Often non-western belief systems and perspectives are incongruent with APA<sub>2</sub> theory and diagnosis (Pedersen, Draguns, Lonner, & Trimble, 2008).

Dr. Cooper Holmes, Professor of Psychology at Emporia State University (ESU), acknowledged the APA<sub>1</sub> and APA<sub>2</sub> did not encourage therapists or psychology students to identify what is “normal” or good mental health (C. Holmes, personal communication, 2008). Rather, the APA<sub>1</sub> and APA<sub>2</sub> focus on finding psychopathology in clients. The criteria for diagnoses are symptom oriented, but have a Eurocentric translation.

Consequently, what behaviors and symptom manifestations are regarded as mental disorders within the context of APA<sub>1</sub> and APA<sub>2</sub> theory, may be understood as normal and healthy in non-western populations, where western concepts of mental illness and coinciding symptoms may not even exist (Dana, 1993; Watters, 2010).

The American Psychiatric Association's most recent *Diagnostic Manual of Mental Disorders* (DSM IV-TR) lacks clarification regarding what constitutes normal. Furthermore, cultural variation concerning symptoms of psychopathology and references about different belief systems based on ethnicity, are marginally addressed in the DSM IV-TR (American Psychiatric Association, 2000; Watters, 2010). Brief cultural references are scattered throughout the definitions of various psychopathologies. Multicultural variation is recognized, but the APA<sub>1</sub> does little to advocate training or identify curriculums in alternate diagnosis of clients from belief systems that vary, nor thoroughly examine the accuracy of current diagnostic standards when clients from non-western cultures do not share the same views and values (Dana, 1993; LaFramboise, 1988; Watters, 2010). Watters (2010) argued "Indigenous forms of mental illness and healing are being bulldozed by disease categories and treatments made in the USA" (p. 3).

Research has suggested (Watters, 2010) mental illness diagnoses such as those described in the DSM IV-TR, do not occur equally across the globe. Every culture has its own unique ideas about behavioral/mental health and mental illness. For example, what would be considered criteria for symptoms of schizophrenia, schizoaffective disorder, or mania with hallucinogenic features in the DSM IV-TR are viewed in the Fertile Crescent

of the Middle East as *zar*, a mental illness stemming from spirit possession with symptoms of crying, laughing, shouting, and singing (Watters, 2010).

Specific mental illnesses or mental illness related symptom sets have not manifested at the same rates through time, even within the same culture, environment, and specific populations. In the mid-nineteenth century thousands of upper-class women of European descent were documented as requiring episodes of bed rest due to the sudden onset of hysterical leg paralysis (Watters, 2010). Since the late 1900s, hysterical leg paralysis among wealthy women of European descent has been relatively non-existent. Many of the mental illnesses in the DSM IV-TR did not exist, as evidenced by lack of recorded symptom manifestation, 50 years prior to its publication (Watters, 2010).

APA<sub>1</sub> and APA<sub>2</sub> research sought and glorified evidence of biological, biochemical, and genetic causes and validation of DSM IV-TR mental illnesses. Considerably less research money was spent to explore the cultural implications of mental illness symptom manifestation or variations of cultural interpretations. Cultural context is frequently ignored.

Beginning in the late 1960s, for a period of 25 years, the World Health Organization (WHO) conducted a series of studies on schizophrenia in several countries across the world (Watters, 2010). The World Health Organization discovered that people diagnosed with schizophrenia in more industrialized nations, such as the United States, Denmark, and Taiwan, had much higher rates of impairment, shorter periods of remission, and reduced social functioning in comparison to less industrialized nations such as Columbia, India, and Nigeria (Watters, 2010). Nations with the greatest use of technology, including high-tech brain research, sophisticated medicines and medical

equipment, and well-financed research institutions had the highest incidence of low functioning individuals with schizophrenia. Despite implications from the WHO study that culture and environment play a significant role in mental illness recovery, rates, and symptom manifestation, few studies have examined this topic. Furthermore, more than a decade after the WHO work was completed, not one credible study explained the cross-cultural variations in people with schizophrenia (Watters, 2010).

Mental health research in the United States confirms ethnic minorities' underuse of the APA<sub>1</sub> and APA<sub>2</sub> models of mental health treatment (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004, p. 411). Although prevalence rates for mental health issues in ethnic minorities are similar to those in the majority population, ethnic minorities "are less likely than Whites to seek treatment from traditional mental health specialists and are underrepresented in participation in the mental health services provided" (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004, p. 411).

Application of western medicine and psychology are frequently ineffective in treatment of non-western clients unless practitioners learn to acknowledge and incorporate non-western belief systems in the language of treatment. Research (Moodly, & West, 2005) has demonstrated that one's overall health is affected by levels of comfort and belief in the treatment being administered. A merger of traditional healing, western medicine and psychology is necessary for the field of healthcare to become truly universal and inclusive (Moodly, & West, 2005). Unification of different behavioral/mental health systems would increase the effectiveness and comfort of treatment for western and non-western clients alike.

## **Indigenous/Traditional Healing**

Whether in Africa or South America, Europe or Asia, indigenous and traditional healers throughout the globe have the commonality of utilizing spirituality, community, culture, and the environment for healing. Symbolism, imagery, art, chants, dances, and song are used for healing and aide in the remembrance of rituals that are passed down verbally and visually through generations. Imagination, ritual, and imagery take precedence in the healing process (Garrett, & Portman, 2006; Marks, 2006). The natural world is sacred and a reflection of the spiritual. Traditional healers, sometimes referred to as shamans or medicine people, recognize the intricacies of the natural world and how the patient's relationships with these varying systems affect well-being (Dufrene, 1991).

Traditional healing practices rarely distinguish between the mind and body, unlike western medicine and psychiatry (Achterberg, 1985; Dufrene, 1991; Koss-Chioino, 1995). Traditional practitioners use a holistic approach in healing and diagnosis. Biological functions do not take precedence when diagnosing and treating an ailment. Differences in paradigm orientation between western healing theory and traditional may be viewed as “*etic* (scientific, universal) versus *emic* (the insider, relativistic view)” (Koss-Chioino, 1995, p.147). While the treatment goal in western medicine and psychology may be to cure an illness, alleviate pain, or save a person's life, indigenous and traditional healers strive for spiritual development and harmony with the universe. Imagery functions as a placebo, guide, and metaphor in indigenous healing. The traditional healer takes advantage of the mind's capacity for imagination through metaphorical ceremonies, interpretations of events or dreams, and ritual (Achterberg, 1985; Dufrene, 1991; Koss-Chioino, 1995).

Traditional healing has been categorized by Achterberg (1985), one of the original founders of the alternative health movement, as having two fundamental methods in the use of imagery with patients. *Preverbal* imagery refers to patients' use of their imagination to affect their physical well-being (Achterberg, 1985). Metaphorical images interact with and influence the body's tissues, organs, and cells for a healing change. *Preverbal* imagery utilizes a different part of the brain than verbal forms of communication (Achterberg, 1985). *Transpersonal* imagery is utilized by the traditional healer, or others to cause harm to the patient, by "transferring" information from the traditional healer's or harm doer's consciousness to affect the physical state of another (Achterberg, 1985). Scientific methodology has verified the effects of *preverbal* imagery in healing. Science has not yet developed tools to record the existence or efficacy of *transpersonal* imagery. Nonetheless, qualitative researchers, such as anthropologists and medical historians, are able to verify the existence and use of *transpersonal* imagery dating back more than 20,000 years (Achterberg, 1985).

## **Art Therapy**

**History.** The foundations of art therapy were heavily influenced in the 19<sup>th</sup> and 20<sup>th</sup> century by American and European psychologists' and psychiatrists' interest in the unconscious (Rubin, 1999). As Freud and Jung gained popularity (Rubin, 1999), western artists delved into metaphor, symbolism in imagery, alternative perspectives, and indigenous or tribal thought processes and belief systems. Around this same time, a group of European psychiatrists (Rubin, 1999) became interested in spontaneous art created by the mentally ill. Some collected art work and analyzed its content. These psychiatrists were interested in the processes of spontaneous art making during psychotic breaks and



the effect on patients while they created the art. Studies and art images were soon published; the extensive collections of Viennese art historian and psychiatrist Hans Prinzhorn are the most well known (Rubin, 1999).

The emergence of projective testing in clinical psychology further spurred the development of the art therapy field (Rubin, 1999). Psychologists and psychiatrists began viewing art as a tool for assessment and incorporated art into psychotherapy. Art media such as finger-paint were viewed as potential tools for diagnosis, and treatment of clients and students. Previously, art education focused on basic principles of art and students were encouraged to learn “good” art from “bad;” technique and skill were emphasized. Art was no longer exclusively for the bourgeois, as an aesthetic or entertainment, but instead was explored as a potential tool in psychology and education (Rubin, 1999).

Margaret Naumberg and Edith Kramer are credited as the founders of the American Art Therapy movement (Rubin, 1999). Both had backgrounds in child development, analytic theory, art, and education (Rubin, 1999). Naumberg (Rubin, 1999) stressed the therapeutic aspects of interpretation and symbol systems in art therapy. She maintained art was from the unconscious; art facilitated symbolic communication and the non-verbal language of the unconscious. Clients could access an unconscious dream-like domain through spontaneous art making, and the symbolic content of the artwork could be used for diagnosis as well as verbal processing (Rubin, 1999).

Conversely, Kramer’s work (Rubin, 1999) emphasized the art making process in art therapy. She argued that the process of making art was therapeutic in its own right, without analyzation of the content. Clients could sublimate traumatic experiences, conflicted feelings, and unhealthy impulses through visual art making. Through this

process, the ego was facilitated down the transcendent road toward synthesis and integration (Rubin, 1999).

**The art therapy process.** The field of art therapy developed with the recognition of the importance of art in mental health and spiritual healing. The creative process was viewed as an invaluable therapeutic tool that offered an alternative to verbal communication and empowered clients while assisting them to access subconscious material that may not be accessible in talk therapy (Malchiodi, 1998).

Generally, art therapy combines art making with verbal discussion of the artwork and probing the emotional process that occurred while making the art (Rubin, 2005). Assessments and art directives may be administered to evaluate the client. For example (Rubin, 2005), the scribble drawing assessment was developed in the 1940s. The technique was used to facilitate spontaneous expression and help release imagery dormant in participants' unconscious (Rubin, 2005). The Kinetic Family Drawing (KFD) is a projective assessment technique akin to those that inspired the formation of the field of art therapy, designed to reveal participants' attitudes about their family and family dynamics, increasing their understanding of development, self-concept, and interpersonal relationships (Brooke, 2004).

Sometimes an art therapist will give a client a specific art directive, and other times the client will decide the terms of the art therapy session. The universality of art making enables art therapists to work with individuals from diverse cultures, transcending culture specific limitations one might encounter when conducting more traditional forms of APA<sub>2</sub> psychological methods, such as verbal counseling.

**Theory.** Art therapists use a wide range of theoretical models for intervention and the facilitation of treatment processes (Rubin, 1999); psychological approaches influence therapeutic interactions with clients. The theoretical models are categorized roughly as psychodynamic, humanistic, psycho-educational, systemic, and integrative. Within these main theoretical categories are several sub-categories (Rubin, 1999).

Psychodynamic art therapy approaches are heavily influenced by Freudian and Jungian theories (Rubin, 1999) of psychoanalysis (Freud) and analytic therapy (Jung). They include the use of discovery and insight, sublimation, object relations, self-psychology, and the recognition of the healing powers in art. Psychoanalytic art therapy makes the “unconscious conscious” which ultimately leads to insight (Rubin, 1999). In Jungian art therapy, the use of the imagination is emphasized in the language of treatment. Imaginary worlds are explored, and images are analyzed for their collective origin and universal archetypal meaning. The context of the client’s personal symbolism has greater weight than the art therapist’s interpretation (Rubin, 1999).

The emphasis of humanistic approaches to art therapy is grounded in the belief that humans are constantly in a stage of growth and development, and that they possess the inherent capacity for self-healing and self-responsibility for improvement (Rubin, 1999). The art therapist becomes the catalytic energy for change and acts as a mirror for the client to acknowledge the self. Thus, the art therapist is regarded as a tool for the client to utilize in the treatment process. Humanistic approaches of art therapy include phenomenological, gestalt, humanistic, person-centered, and the utilization of art as a spiritual path (Rubin, 1999).

Art therapists implementing psycho-educational approaches in art therapy encourage their clients to learn (Rubin, 1999). They create art therapy sessions designed to teach clients new skills, behaviors, or thought patterns. Learning in the psycho-educational approaches may be categorized as Pavlovian, with an emphasis on emotional learning and understanding, or Skinnerian, which emphasizes changing observable behavior with contingent reinforcement (Rubin, 1999). Ideas such as *classical conditioning* (through repetition a desired response is achieved), *systematic desensitization* (repetitive exposure affects a previous response to decrease or cease), and *operant conditioning* (behaviors are influenced by actions and events following them) are part of the art therapy process within this context (Rubin, 1999). Psycho-educational approaches to art therapy include behavioral, cognitive-behavioral, developmental, as well as assessment and development of cognitive skills through art (Rubin, 1999).

Within systemic approaches to art therapy, clients are viewed as individuals existing within various systems (Rubin, 1999). These systems can be as small as the client's immediate nuclear family, or as large as the country in which he or she lives. A client's problems are thought to be relationship oriented and interpersonal. Therefore, the system(s) in which the client functions is incorporated into the treatment process.

Systemic approaches include family and group art therapy (Rubin, 1999).

Integrative approaches to art therapy have become the dominant theoretical orientation (Rubin, 1999). Integrative approaches utilize multiple theoretical orientations. Art therapists have in-depth understanding of the theoretical models they use, and through time, experience, and intuition will know when and with whom to utilize specific theories. Art therapists strive to find a "goodness of fit" (the suitable approach both the

art therapist and client are comfortable with for addressing a particular client's specific needs) with the clients, theoretical models, and treatment process (Rubin, 1999).

**Art therapy with Native Americans.** A small number of articles have been published on using art therapy or the creative arts in counseling with Native American clients. Most of the articles are written qualitatively and the information is presented as case studies of client therapist interactions on reservations, with a Native American population, or with an individual Native American client (Appleton & Dykeman, 1996; Ferrara, 1998; Moody, 1995). Phoebe M. Farris-Dufrene is one of the few Native American art therapists who has published articles addressing ethical issues using art therapy with Native Americans. Recognizing a link between art therapy and indigenous/traditional healing, Farris-Dufrene said she compared the educational training of an art therapist with the path to becoming a traditional healer in her doctoral dissertation (P. Farris-Dufrene, personal communication, December 8, 2008).

When using art therapy with Native American populations, it is important to understand the particular tribal affiliations and specific cultural nuances of each tribe the clients belong. Art is viewed less as an aesthetic achievement, but rather as inseparable from the rituals of everyday life. Art, religion, and indigenous/traditional healing meld together, without distinctions between them. The Native American client familiar with traditional healing is accustomed to practitioners and belief systems that incorporate symbolism and the roles of society, spirituality, and psychology into the treatment process (Coleman & Farris-Dufrene, 1994b; Farris-Dufrene, & Garrett, 1998).

The Native American client who uses traditional healers and maintains a traditional belief system may be more comfortable in an environment that incorporates

and acknowledges the natural world and the connections we have with the earth, rather than a sterile office setting that does not acknowledge spirituality (Coleman & Farris-Dufrene, 1994b; Farris-Dufrene, & Garrett, 1998). Therefore, the art therapist may wish to consider beginning and ending an art therapy session with a prayer or other type of acknowledgment of the client's spiritual beliefs, thus incorporating traditional concepts of healing as part of the treatment process. Traditional healers acknowledge that the power to heal comes from outside of them; therefore, they give thanks and recognition to the spirit realm at the commencement and close of the ceremony or healing process (Coleman & Farris-Dufrene, 1994b; Farris-Dufrene, & Garrett, 1998).

**Working outside one's ethnicity.** Non-Native American therapists must be aware of and address cultural bias when working with Native American clients. They must understand their own cultural beliefs, ideas, perceptions, values, and thoughts, and realize how they may affect the client and therapy process. Because the philosophical foundations of art therapy developed from Eurocentric and American Psychological theory, an art therapist must continually evaluate if the therapeutic process is congruent with the cultural ideals and thought process of the client (Coleman, & Farris-Dufrene, 1994b; Farris-Dufrene, & Garrett, 1998).

Drawing from her experiences as an art therapist on the Penobscot Indian Nation reservation, Moody (1995) explored the challenges of being a "non-Indian" working with Native American clients. Initially she felt her worldview acknowledged the interconnectedness of the mind, body, and spirit; she felt a link with nature, and embraced the oneness of all existence. Based on what she had previously read, she thought her values would parallel the beliefs of Native Americans. What Moody

discovered at the Penobscot reservation, however, was distrust of and anger towards non-Native people, regardless of perceived similarities.

A non-Native American art therapist working with Native Americans needs to establish trust with the Native American population. Doing so requires recognition of the historical injustices between cultures, especially for art therapists of Euro-American heritage. Sometimes learning about Native American culture from the people of a particular tribe can be quite difficult. There may be secrecy and protection of traditional Native American ceremony, beliefs, and history resulting from hundreds of years of forced assimilation and genocide. The only alternative may be the writings of non-Natives, to which some Native Americans respond with skepticism, distrust, and resentment, but may be necessary to utilize for an initial understanding of a particular tribe (Moody, 1995).

Moody (1995) emphasized that art therapists should not interpret Native American clients' imagery or judge their values. Native American culture is rich in symbolism, and each tribe has its own value set and symbol system. The non-Native American art therapist should act as an observer and student of culture, allowing the clients to set the desired pace and to vocalize their insights and symbolisms. The art therapist must be patient with Native American clients and strive to understand the complexities with which the clients may be wrestling internally such as sharing their most intimate details with someone from an ethnic group whom they may have learned to distrust for survival (Moody, 1995).

Belonging to and working together as a community, and achieving group consensus are highly valued among Native American populations (Coleman, & Farris-

Dufrene, 1994b; Moody, 1995). Coleman and Farris-Dufrene (1994b) and Moody (1995) emphasized the importance of cultural immersion and community participation for an art therapist working with Native Americans. The art therapist needs to become part of the community to gain a better understanding of cultural beliefs and develop trust.

**Personal experience.** My own inquiries into Native American perceptions of mental health, more specifically, Native American perceptions of western or APA<sub>1</sub> and APA<sub>2</sub> psychological constructs, indigenous/traditional healing, and art therapy began with a research project in the spring of 2009 at the Lawrence High School's 2009 Spring Pow Wow in Lawrence, Kansas. I set up an authorized table in the vendor area of the pow wow grounds and sat from the start of the pow wow from the morning to early evening, offering free snacks in exchange for participation in my research. Twenty-five people ages 15 to 56, all of whom identified themselves as Native Americans raised in a Native American social and cultural context volunteered (Drumm, 2009).

Participants completed two demographic surveys. The first survey collected information about age, gender, tribal and spiritual affiliations, places they grew up and currently lived, and finally perceived efficacy of and attitudes toward western psychology, indigenous/traditional healing, and art therapy. The second survey encouraged participants to reflect on perceptions of western psychology, indigenous/traditional healing, and art therapy; it also had a section exploring attitudinal changes that may have occurred after each participant experienced the scribble drawing assessment (Drumm, 2009).

The observations from the spring 2009 Pow Wow study were the following: 1) Most participants had previously participated in indigenous/traditional healing and had



positive feedback about their experiences. 2) Most of the participants had never heard of art therapy but enjoyed the scribble drawing assessment and were interested in learning more about the field of art therapy. 3) The majority of participants had little or no experiences or familiarity with western psychology, and the few who did had either mostly negative or both negative and positive comments. One participant summarized feelings about western psychology with a single word, “wary.” Another participant was “not as comfortable with western psychology as with traditional healing” (Drumm, 2009).

In the summer of 2009, I interned with Navajo activist and teacher Kelly Hubbell at a workshop in St. Michael’s, AZ called “I Am Art.” The workshop was sponsored by Communities Healing through Art (CHART), and provided local children from the Navajo reservation the opportunity to participate in various types of creative art projects. I Am Art had an urban theme; it provided children opportunities to learn how to break dance, make graffiti art, create raps and rhymes, draw and paint, and make artist trading cards. Art-making was utilized as a means for socializing, learning new skills, and occupying the children’s time in a productive and healthy way.

From the fall of 2009 through spring of 2010, I was a graduate student art therapy intern working with Native American college students at Haskell Indian Nations University in Lawrence, KS as part of the Sedna Project, founded in 2005 by ESU art therapy faculty member Libby Schmanke, MS, ATR-BC. The project was funded by the Kansas Crime Victims Assistance Fund for the 2009-2010 school year and overseen by GaDuGi SafeCenter of Lawrence, KS, originally known as the Sexual Assault Crisis Center. I facilitated an open art studio for the Haskell students, helped introduce them to

the field of art therapy and the art therapy program at ESU, and offered art therapy directives individually or in groups to students who were interested. My experiences as an intern with both “I Am Art” and Sedna Projects allowed me to develop a better understanding of Native American participants’ reception and reactions to art therapy.

**Art therapy as a bridge.** Art therapy can serve as a bridge between the American Psychological and Psychiatric Associations models of mental health treatment and the traditional healing methods of indigenous cultures. Arrington (2005) suggested art therapy is a more inviting method than traditional APA<sub>1</sub> and APA<sub>2</sub> verbal therapies or psychotherapy because of the universality of the creative arts addressing emotional issues and mental disturbances among populations that do not subscribe to a Eurocentric value system. Coleman & Farris-Dufrene, (1996) argued art therapists would make excellent intermediaries between clients familiar with indigenous/traditional healing who are seeking therapy in mainstream American society.

Communication and emotional expression using visual imagery are the preferred methods of treatment in art therapy. Verbalization is often a component of art therapy, but not the focus. When language barriers exist, talk therapy is useless; however, an art therapist can utilize both the therapeutic process of making art and art’s non-verbal symbol systems. Clients whose primary language is different from the therapist’s or whose cultural background teaches not to share emotional issues and feelings may find art therapy more comfortable than traditional talk therapy. It is more comfortable for some clients to focus on and talk about the artwork created rather than herself (Coleman, & Farris-Dufrene, 1994a; Coleman, & Farris-Dufrene, 1994b).

Art therapy is frequently met with skepticism from practitioners of APA<sub>1</sub> and APA<sub>2</sub> psychology due to limited quantitative research validating art therapy techniques (McNiff, 1992). Art therapists understand and believe in the value of their treatment methods but lack the support of quantitative research to demonstrate the value of a particular method, or substantiate what art processes or symbols reflect about a client (McNiff, 1992). Indigenous healers and art therapists share the struggle to have their methods validated by the National Institute of Mental Health, The American Psychological and Psychiatric Associations, and mainstream America.

### **Hypotheses**

The review of literature revealed that to be more inclusive and truly meet the needs of a variety of populations, it is of utmost importance to further validate and explore methods which may offer alternatives to the standard western or APA<sub>1</sub> and APA<sub>2</sub> psychological constructs for behavioral/mental health treatment in the United States. The hypothesis is that art therapy is an appealing and culturally appropriate form of therapy for Native Americans. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing; especially those who do not have immediate access to traditional healers and are wary of mainstream mental health facilities heavily influenced by psychological constructs of the American Psychological and Psychiatric Associations.

Rather than interviewing Native American behavioral health clients about their perceptions of art therapy, the behavioral health staff at an Indian Health Services facility located on a Native American Reservation where traditional healing practices are still common, were questioned whether they felt art therapy would work with their clients and

for what reason. The initial focus of the research was on staff perceptions of art therapy so as not to be invasive to the Native American behavioral health clients, and due to other research limitations. Making an inquiry with the staff revealed how an art therapist may be regarded on a multi-disciplinary treatment team and whether the staff at an Indian Health Service behavioral health clinic would welcome art therapy as part of services offered. It also revealed how art therapy may be used as a bridge or as a common factor between the behavioral health clinic staff and the Native Medicine staff (traditional healers) for more congruent client treatment and assessment.

A secondary hypothesis developed during the middle of the research. Cultural competence of the therapeutic service providers in relation to the population being served (i.e. understanding of nuances within the culture such as spirituality, taboos, political history, indigenous/traditional beliefs etc.) as well as one's personal background (i.e. ethnicity, spiritual affiliation, relationship to population etc.) has relevance in patient outcomes and staff cohesion.

## CHAPTER 2

### METHOD

This qualitative study was conducted to identify whether art therapy would be beneficial to use with Native American clients, as an analysis of behavioral health staff perceptions of their specific role on a multi-disciplinary treatment team, and whether hiring an art therapist would be a valuable and appreciated addition to the behavioral health department at an Indian Health Service facility. Understanding was gained through the analysis of in-person interviews of staff. The focus for the data synopsis was how an art therapist would fit into the treatment team, the perceptions of each behavioral health facilitator about art therapy, and their evaluations of the desirability in using art therapy with Native Americans; given that the hypothesis is art therapy is an appealing and culturally appropriate form of therapy for Native Americans. Behavioral health staff at an Indian Health Services facility located on a Native American Reservation where traditional healing practices are still common, were questioned whether they felt art therapy would work with their clients and for what reason. The Navajo Nation uses the term behavioral health rather than the more commonly used phrase mental health, therefore both terms health have been incorporated throughout this thesis.

**Participants.** The research was conducted primarily with the behavioral health treatment staff of the Chinle Comprehensive Health Care Facility (CCHCF) in Chinle, AZ. A minimum of five CCHCF Behavioral Health staff, one school counselor with whom the CCHCF Behavioral Health Department Director and child psychiatrist worked in Chinle, AZ public schools, and one male and one female traditional counselor/medicine person from the CCHCF Native Medicine staff were sought to

volunteer as participants for in-person, open-ended interviews. Thirteen behavioral health providers volunteered and were interviewed for the study.

**Interviews.** The interviews covered topics such as staff reflections on their profession, their thoughts on working in a behavioral health facility using integrative methods, and their thoughts on art therapy as a form of treatment (see Appendix A and B for initial interview questions). Participation was voluntary. Participants filled out a consent form of my own design (see Appendix C). I kept a copy of each signed consent form for my records and offered each participant a copy.

Grounded theory (Bell, 2005) was incorporated into the process of conducting the interview portion of the research and for the final data analysis. Grounded theory is the antithesis of method; it allows the researcher to derive theory from the data once obtained. Grounded theory is an iterative process where meaning flows in a cycle of exchange, each part of the data influences another, building upon existing and creating new theory. The theory builds upon itself when new ideas emerge from the data (Bell, 2005).

**Setting.** Chinle, Az is a town located on the Navajo Reservation with a population of 5,366 people as of the 2000 census. The majority of the residents are Navajo. Chinle is in a more isolated part of the reservation, having several smaller towns in the surrounding areas. Many tourists, both national and international, visit Chinle throughout the year to experience the National Park Service Department of the Interior maintained Canyon de Chelly. Canyon de Chelly is “comprised entirely of Navajo Tribal Trust Land” though managed by the Department of the Interior (U.S. Department of the Interior Laws and Policies, NPS, 2012, para. 2).

## **Design**

Formal interview data was collected through the phenomenological method of interviewing. The interview setting and methodology for obtaining information had an emic focus; participants had a role in how and when the information was obtained. While collecting data, progressive focusing was used. Information obtained through field research and observation was used to create questions for the interviews.

Data was collected regarding participants' perspectives through the phenomenological methods of open-ended interviews and participant observation. The phenomenological perspective (Wadson, 1992) is one of two major theoretical perspectives used in the social sciences. Understanding is derived from in-depth interviews, observation, and other methods that provide descriptive data. The perceptions and beliefs of the subjects, and how they understand and experience their actions, are the primary foci of phenomenological inquiry (Wadson, 1992).

The phenomenological perspective falls under the data classification of qualitative research. Qualitative research is subjective with an emphasis on the experiences of the researcher as well as the participants involved in the study. Central tendency and variability are used for organizing and communicating results. The qualitative researcher looks for the emergence of meaning from the data collected (Carolan, 2001).

I also utilized the Social Constructivist Theory of Materiality (SCTM) (Moon, 2010) for further insight. SCTM addresses how the context and interaction of various relationships influence the meaning of specific art materials. History, society, the environment, availability, culture and many other features effect the significance and

symbolism ascribed by the artists to the materials chosen for each particular art piece (Moon, 2010).

**Community immersion.** The thesis research took place on the Navajo reservation and bordering towns. To provide a context for data collected in the interviews, cultural information was obtained through community immersion, friendships, a brief art therapy internship on the reservation, employment, and field research. I also took two classes about Navajo History and Culture at the Diné College in Shiprock, New Mexico.

My community and cultural immersion began in the fall of 2010 when I worked as an art therapy intern at the DBHS operated Navajo Regional Behavioral Health Center (NRBHC) in Shiprock, New Mexico. I provided art therapy groups for the men's residential unit, the male adolescent residential unit, and the outpatient clinic. I also provided art therapy services for several months at the beginning of 2011 to the Healing Drop-In Center in Shiprock, New Mexico. The Drop-In Center is a psychosocial facility offering different support groups and meetings such as AA, sweat lodge, volleyball, a pool table, a community garden, and more.

For a source of income, I worked as a substitute teacher for the Central Consolidated School District #22 between December of 2010 through October of 2012 and as a temporary/on-call Mental Health Assistant for the Presbyterian Medical Services San Juan County Adolescent Residential Treatment Center (RTC) from June 2011 to January 2012. Central Consolidated School District mainly encompasses schools on the Navajo Reservation. I worked as a permanent substitute for Tse Bit Ai Middle School for the Spring of 2011 and for Eva B. Elementary School for the fall and winter of 2011-12.



Both Tse Bit Ai and Eva B. are located in Shiprock, New Mexico, which is on the Navajo Reservation.

The RTC is located in Farmington, New Mexico, a border town of the Navajo Reservation, about 30 miles east of Shiprock. Residents are placed from agencies throughout the state of New Mexico, including the Juvenile Detention Center across the street, serving both adolescent males and females from the ages of 12 to 18. Frequently the treatment unit had a mix of both ethnically Navajo as well as European American residents. By working for the school district, the RTC, and interning, I became part of the community surrounding Shiprock and gained a better understanding of Navajo youth, staff and patients within the DBHS system, and Navajo culture.

I lived on the Navajo Reservation for over a year, in various chapters (what one may think of as districts) including Cudei, Shiprock, and Two Grey Hills as well as the border town of Farmington, New Mexico. I experienced living in Navajo Nation Housing in Cudei and Two Grey Hills for five months. For seven months, I lived in a friend's hogan in Shiprock. Life in the hogan involved managing dust from the dirt floor, visits to the mountains for firewood, chopping firewood, and building nightly fires to keep warm.

My mentor Ray Daw, the former Director for the Department of Behavioral Health Services (DBHS) for the Navajo Nation, provided insight about the Navajo Nation, the differences between DBHS and IHS (DBHS is operated by the Navajo Nation, IHS is operated by the Federal government,) particulars about Navajo culture, and friendship. Ray Daw is a Diné and English speaking Navajo man from Gallup, New Mexico. He has worked in the field of mental health for more than 20 years and received a Masters in Counseling Psychology from the University of New Mexico. He was

actively involved in consultation work throughout the United States on various topics in mental health related to Native Americans. He also worked with Dr. Brave Heart to address historical trauma experienced by Native Americans through workshops and lectures. In the fall of 2011, he began employment as the Behavioral Health Administrator at Yukon-Kuskokwim Health Corporation in Bethel, Alaska.

I worked with my mentor, the treatment staff, adoptive family, and friends as well as local residents of the Navajo Nation and surrounding areas to increase my tacit knowledge of the Navajo population who were receiving behavioral health services. Observations were discussed with my mentor as well as my thesis committee members at Emporia State University, and local friends living on or near the Navajo Reservation.

### **Procedure**

Participants were asked to volunteer for in-person, open-ended, one-on-one interviews covering topics such as their profession, their thoughts on working with the Navajo, and reflections on art therapy as a treatment method. During the interviews, I administered the scribble drawing assessment as an art therapy directive (see Appendix D for a brief description and history of the scribble drawing assessment), to provide participants with an introductory art therapy experience and an opportunity to give feedback. Once the participant completed the scribble drawing, the interview was continued with follow-up questions.

The length and number of interviews of each participant varied, and depended on such factors as willingness to speak and time available. Interviews were recorded with permission through hand written notes, and using a Sony IC recorder. All interviews were administered individually.

The interviews served to help the participating behavioral health treatment staff to: 1.) Reflect on their roles in a treatment team 2.) Analyze how their specific training could help the healing process in interaction with the other behavioral/mental health practitioners 3.) Understand how their contributions enhanced patients' recovery process and the patients' behavioral/mental health maintenance overall, and 4.) Evaluate the benefits of using art therapy with patients and having an art therapist as permanent behavioral health treatment staff.

### **Data Analysis**

My internship experiences on the Navajo Reservation introduced supplementary concepts to explore in addition to or enhancement of participant perspectives. While collecting data, I used progressive focusing; data collected through observation informed questions for the interviews. During interviews, I addressed how my perspective influenced what I was hearing, especially while interpreting what participants were conveying.

The interview setting and methodology for obtaining information had an emic focus; participants had a role in how and when the information was obtained. While reading notes and listening to interview responses, literal, reflexive, and interpretative modes of analysis were used. Surveys and interview information were taken literally. Data was examined using a system through which common themes were organized and conclusions made. The artwork created during the art therapy scribble assessment, was not used as a tool to measure the psychological functioning of participants; the purpose of the directive solely being the participants' experience of the scribble technique, offering a reference point for what art therapy entails.

**Challenges to research.** Initially, the research was planned to take place in the fall of 2010. Due to complications with internship sites, and the unexpected involvement and processing with the Navajo Nation IRB (see Appendix E), the interviews did not take place until the summer of 2011. I had to first seek permission to begin the interviews with letters of approval from the Canyon De Chelly Comprehensive Health Services Board of Directors (see Appendix F), the CCHCF Chief Executive Officer (see Appendix G), the Chinle Chapter Government (see Appendix H), the Governing Board of Chinle Unified School District NO. 24 (see Appendix I), the Superintendent of the Chinle Unified School District, Dr. Jesus V. de la Garza (see Appendix J), and the DBHS/IHS Native Medicine staff representative. Acquiring the letters of approval took months and required I attend numerous meetings in Chinle, which was up to two hours driving distance from where I lived.

I was mandated to make several changes to my Navajo Nation IRB proposal. The Navajo Nation IRB process was complicated, and involved, especially for a first time graduate research student. Each change required my attendance at a monthly IRB meeting, involving a request to be on the agenda for that month, and a vote from the IRB on whether the changes would be approved. I attended more than five Navajo Nation IRB meetings.

The wording in my Navajo Nation IRB proposal to include the Native Medicine staff in the thesis study had to be changed several times. I attended two different meetings to gain approval to conduct the final two research interviews with the Native Medicine staff/traditional practitioners. I was given final permission by the Navajo Nation IRB to do the interviews at the January 2012 IRB meeting.

Though final permission was granted, a few more steps were necessary to conduct the interviews with the Native Medicine staff. I first needed a letter of approval from the Navajo Nation IRB to submit to the DBHS/IHS Native Medicine staff representative to get approval from their department. I was told at the January 2012 IRB meeting to submit the corrected Navajo Nation IRB proposal to the Chairwoman of the IRB via email.

I submitted a copy of the new proposal to Chairwoman Bicenti-Pigman as well as her secretary Louise Joe the day after the January 2012 IRB meeting. No approval letter was sent from the Navajo Nation IRB to the DBHS/IHS Native Medicine staff representative nor to me. After a follow-up phone call to Louise Joe, I learned that I would need to attend yet another IRB meeting to get the letter of approval. At this point, I decided I would not continue my pursuit of interviewing the CCHCF Native Medicine staff/traditional practitioners.

### **Summary**

This study utilized tools from field research and participant observation to gather and better understand the perspectives of behavioral health treatment staff concerning their roles as healers, therapists, or behavioral health facilitators while serving the Navajo population. Participants were surveyed about their opinions regarding the use of art therapy with the Navajo. Though Grounded Theory was utilized to quantify data, a hypothesis about the outcome was made prior to the research being conducted. Normally when using Grounded Theory, a hypothesis is created from the data gathered during research and formulated after the research has been conducted. A secondary hypothesis did develop during the thesis research, supporting the initial Grounded Theory orientation to the thesis research. The purpose of this study was to evaluate the desirability of using

art therapy with indigenous populations such as the Navajo as a treatment method in conjunction with or as an alternative to American Psychological and Psychiatric Associations techniques and indigenous traditional healing methods.

## CHAPTER 3

### RESULTS

The majority of feedback regarding whether art therapy would be beneficial for Native American clients was positive. The hypothesis was realized, according to the participants' responses, one might deduce that art therapy is an appealing and culturally appropriate form of therapy for Native Americans. The secondary hypothesis, that cultural competence of the therapeutic service providers in relation to the population being served has relevance in patient outcomes and staff cohesion, started to manifest and developed due to the clear distinction between the perspectives of Navajo and non-Navajo participants in the way questions were answered, their life background, and beliefs.

**Unanticipated Findings.** Unwittingly, the thesis research helped reveal tension among staff members. This tension can affect patient outcomes, as well as, decisions regarding whether or not a patient wishes to use the behavioral health department services. The administrative and staffing structure of IHS facilities can be problematic, a source of conflict, and a reminder of historical trauma as most staff in the administrative, directorial, or higher paid positions are non-Navajo.

An unexpected outcome of the interviews was the disclosure of staff tension due to cultural differences; this issue led to the introduction of a cultural component at the CCHCF Behavioral Health Department weekly staff meetings addressing tensions among staff and between staff and clients due to cultural differences. The department director felt the new addition to the weekly meetings so helpful and positive, that he wanted to push for a colloquy in cross-cultural engagement to be incorporated in all staff meetings

throughout the entire CCHCF facility. Upon my request, the department director wrote a letter addressed to the Navajo Nation IRB about the influence the thesis interviews had on the behavioral health department staff (see Appendix K for a copy of the letter).

All of the participants who were Navajo had an immediate cultural relationship to the people to whom they provided services. An innate understanding existed about what the patients' daily lives were like, from where they were coming, their perspectives and values, understandings that would take years to learn by someone coming in from 'the outside.' The Navajo participants had continuity of place and culture enhancing their services. The participants of mixed European heritage offered anonymity, and different ways of thinking about the world. The intentions of the 'outsiders' coming in to the Navajo Reservation to work and provide services may be questioned by Navajo staff and patients alike. It could take years for acceptance and integration of an 'outsider' into the unfamiliar community.

**Format.** Chapter three was arranged first with identifiers for each participant in terms of sex, age, profession, background one was raised, spiritual affiliations, and parts of the United States or globe one lived and travelled. The personal questions about each participant were necessary to identify basic similarities and differences in Navajo and Non-Navajo participants from early stages of life to the time when the interviews were conducted. The information was arranged into table formation in the Participant Personal Identity Table (see Appendix L for the Participant Personal Identity Table).

The second part of chapter three included more in-depth quotations from participants' interview responses. The main headings or themes highlighted were: Definitions of Mental Health/Illness, Understanding of Treatment Team, and Art



Therapy. The themes were chosen as summarizations from the Professional Interview Questions asked each participant (see Appendix B for the list of Professional Interview Questions).

The particular themes chosen were necessary to identify whether the participants had different concepts, opinions, and understanding of: (1) mental health, mental illness, and normality (2) professional roles in the behavioral health clinic, and (3) art therapy as a form of treatment for the Native American clients being served and whether an art therapist would be a welcome addition on staff. If differences were found, contributing factors to the variations (i.e. ethnicity, age, sex, profession, academic training, spiritual beliefs, personal identification, etc.) were explored.

Thirteen people were interviewed for the study. Participants' ages ranged from 38 to 68 years old. Of the 13 participants, seven were men and six women. Five women and two men identified as Navajo (one identified himself as both Navajo and Mescalero Apache); the others largely identified as European-American mixed heritage (German, Amish/Mennonite, Mexican, Mexican Indigenous, Cuban, Spanish, Scottish, English, Greek, Cherokee/Native American, Irish, Austrian, French, and Italian).

The professional backgrounds of the participants included three psychiatrists (one also trained in music therapy and Core Shamanism), two clinical psychologists, two school counselors from the Chinle School District, a substance abuse counselor/mental health specialist, a graduate student intern of mental health counseling, and four social workers with educational backgrounds and services offered in mental health, medical social work, and social work supervision. The participants will be referenced in Chapters three and four according to the Participant Personal Identity Table in Appendix K; for

example Participant 1 was the CCHCF Behavioral Health Department Director and child psychiatrist, and Participant 2 was the female psychiatrist who also specialized in music therapy and core shamanism or with defining features from the table such as the male social worker or the clinical psychologist from Oregon.

Originally, I had intended for the CCHCF Native Medicine staff to be included in the interviews. Multiple changes were made to the Navajo Nation Institutional Review Board (IRB) proposal for this study regarding the appropriate wording to include the traditional counselors/medicine people from the Native Medicine staff as possible interview volunteers. The proceedings with the Navajo Nation IRB for the inclusion of the Native Medicine staff in the study ultimately became problematic and time consuming, thus they were not interviewed.

Redundant and repetitive words and phrases were omitted from the quotes obtained from interviewee responses that have been used in the following pages of this thesis. These include such words and phrases as “Ah, uh, hmm, ok, um, I think, you know, so, and, but, oh, well.”

**Ages/Sex.** The participants who identified as Navajo were the ages of 38, 40, 43, 52, 53, 55, and 59 years old. The six who identified as mixed European heritage were age 39, 48, 54, 59, 64, and 68 years old. The CCHCF Behavioral Health Department Director male= (M) was the youngest working staff member interviewed; he was 39. The graduate student intern female= (F) was 38 years old and was the youngest interviewee. The three psychiatrists’ ages were 39 (M), 48 (F), and 59 (M). The two school counselors were 43 (M) and 64 (F) years old. The two clinical psychologists were 54 (M) and 68 (M). The

four social workers, including the supervisor, were 40 (M), 52 (F), 53 (F), and 59 (F).

The substance abuse counselor/mental health specialist was age 55 (F).

Table 1 presents a brief summary of the participants' ages, professions, and sex, categorizing them under the headings of European Mix/Non-Navajo or Navajo.

<b>Table 1</b>	
<b>MIXED-EUROPEAN PARTICIPANTS</b>	<b>NAVAJO PARTICIPANTS</b>
CCHCF Behavioral Department Director and Child Psychiatrist AGE 39, MALE (M)	Social Worker Supervisor AGE 52, FEMALE (F)
Psychiatrist (trained in music therapy and Core Shamanism) AGE 48, FEMALE (F)	Medical Social Worker AGE 40, MALE (M)
Psychiatrist AGE 59, MALE (M)	Medical Social Worker/ Mental Health Specialist AGE 53, FEMALE (F)
Clinical Psychologist AGE 54, MALE (M)	Medical Social Worker/ Mental Health Counselor AGE 59, FEMALE (F)
Clinical Psychologist AGE 68, MALE (M)	Substance Abuse Counselor/ Mental Health Specialist AGE 55, FEMALE (F)
Elementary School Counselor AGE 64, FEMALE (F)	Graduate Student Intern AGE 38, FEMALE (F)
	Junior High School Counselor AGE 43, MALE (M)

**Professional background.** The mixed European participants had the highest level of academic training. Their interest in the behavioral health profession varied from insight into a crazy upbringing, to philosophical inquiry into reality, human nature, and the meaning of life. None of the participants of mixed European heritage had a specific population they reported being interested in helping, aside from beginning training in pediatrics or family medicine, when initially beginning their careers in the behavioral health field. They attended universities throughout the United States, often far from the places they were raised. The mixed European participants had less personal interest in working on the reservation and with Native American clients than the Navajo participants. For many, curiosity about Native Americans or the need of a job brought them to the reservation.

The Navajo majority of the Navajo participants had degrees in social work. They attended universities in the southwest (Arizona, Utah, New Mexico) near to the places they were raised, the farthest having attended university in southern California. Their interest in the behavioral health field was for many of the same reasons as the participants of mixed European heritage. The biggest difference in each group was that the Navajo participants specifically wanted to help people on the Navajo Reservation or Navajo or Native American people. They wanted to give back to the community in which they grew up or of which they belonged. Some were inspired to attend university and enter the behavioral health field for self-improvement or to create distance from the dysfunction they grew up in a gesture of symbolic transcendence. They repeatedly identified as having been in “their shoes,” (in reference to clients or individuals who were having trouble in their lives) having lived the difficulties of reservation life and being Native

American in a mixed European heritage dominated country. Working at CCHCF Behavioral Health Department or in the Chinle Public School system had a very personal motive.

The CCHCF Behavioral Health Department Director was of Hispanic (originating from Spain and the Canary Islands) and mixed European heritage, with a distant relative who was an indigenous person of Mexico. In addition to being the departmental director, he practiced as a child psychiatrist within the department. At age 39, he was also the youngest staff member interviewed. He had worked with the clinic for six years at the time of the interview. He was originally a philosophy major in college, but was inspired by the practical application of listening, and the art of medicine. He enjoyed the pursuit of identifying the philosophical debate of “what is reality?” with the philosophy of using the entire human body to understand truth, thinking, and reasoning. While living in Louisiana he and his wife learned about employment at CCHCF through his wife’s friend. They both felt Chinle and CCHCF would be a good fit for the next stage in their careers.

The other two psychiatrists on staff were both of mixed European heritage. The oldest was 59 years old and of Amish Mennonite background. His interest in medicine began as a teenager, with an idealized view of the family doctor. This idealization was the catalyst for the pursuit of a career in the field of medicine, initially as a physician. He developed a broadened fascination with public health and eventually went into psychiatry, influenced by his observations that often clients who came in to see him for physical complaints would actually have underlying psychological problems.

His interest in Native American culture transpired while working as a physician in a Mennonite community in the Chaco of the Paraguayan and Argentine border. While there, he was “confronted by the conservative Mennonites.” He was informed that he should not talk about or take seriously other forms of health care, including the traditional practices of the Native peoples which were viewed as demonic in nature. He did not agree with these views and began working with different humanitarian groups and anthropologists rather than the local Mennonites. Many of the Native children from the Chaco asked the psychiatrist about other Natives in the United States, and referred to Native Americans as their brothers and sisters. This sparked his interest in learning more about Native American culture. Upon return to the United States to visit a sister in Albuquerque, he expanded his interest and learned more about Native people in the southwest; this led to jobs on the Navajo reservation where eventually he and his wife served as foster parents for a number of Navajo children.

The third psychiatrist was 48 years old, and trained in music therapy and Core Shamanism; her interest in psychiatry was influenced by a history of mental illness in her family. She wanted to find understanding. She also found the fields of psychiatry and medicine fascinating in that it was still permissible to use intuition as part of the process of diagnosis and treatment. She appreciated the questioning nature of both fields, especially philosophical inquiry regarding “what equates healing” and the science behind what comprises “the totality of life.” However, she found her training in psychiatry to be deficient in preparing students to interact with patients.

The oldest clinical psychologist (age 68) was of mixed European heritage and was born and raised in Aruba. He found himself working on the Navajo reservation after

leaving Grand Cayman. He had formed ideas about Navajo life and culture through reading books by the author Tony Hillerman, but had no clear plan about what he would do after relocating to the reservation. The move from Grand Cayman was prompted by his wife's interest in working with Native American children in the reservation schools as a speech pathologist for the hearing impaired. While attending church camp as a teenager, his wife had heard stories that had fascinated her about the children and life style of Native people, from a man who had previously worked in the Southwest.

The clinical psychologist's academic career began with training as an engineer but he dropped out of the program due to a learning disability. Since childhood, he had an interest in why people think and behave as they do. After a year working on a cotton farm he returned to college and began studying psychology; while there he learned techniques to overcome the limitations of his disability.

The second clinical psychologist interviewed, age 54 believed, "growing up in a crazy family" probably groomed him "to assist in carrying the burden of other people." He said,

The work that we do is the work we were shaped to do early on in life...

Academic pursuits legitimize the work...It's kind of this western notion; we

need to quantify it...to measure it, we need to be able to put it together.

He was of mixed European heritage and had previously worked in cross-cultural settings with Native Americans, including living and working in clinics in Montana, South Dakota, Alaska, and Arizona. He said he always felt a "sense of compassion for the one down," the non-dominant part of society. He also felt a personal affinity for working



cross-culturally that related to culturally diverse dynamics he had experienced in his interracial marriage.

The substance abuse counselor/mental health specialist was a 55 year old Navajo woman. She was the first person to volunteer for the interviews. Like several other staff members, she was influenced by the dysfunction in her family to go into the behavioral health profession. She reflected,

When I grew up, I learned a lot about domestic violence...about alcoholism...

I made my choice a long time ago. I'm never gonna be like them...I

became a nurse first, and then because of some issues I decided to change again and I became a counselor. I wanted to help people, especially the younger ones, because I knew it. I know what it was like when I was in their shoes.

All four of the social workers, including the social work supervisor, were Navajo.

The social worker supervisor was 52 years old and had worked in behavioral health positions as a substance abuse coordinator, a social worker, and a mental health counselor. While hitchhiking in her younger days, she met a woman who was a community health representative; she asked what type of services were needed on the reservation and was told social workers. During her undergraduate studies in sociology, she was recruited into the social work program at the University of Utah by two professors in the American Indian Program.

The only male social worker was 40 years old and was trained as a medical social worker. As a young man, he did not know what he wanted to do in life, so he took a test. It revealed him three things at which he might excel; FBI agent, social worker, or

“something to do with problem solving.” He didn’t want to be an FBI agent, so he chose social work. He “naturally liked helping people, so that fit.”

He returned to the reservation (from his studies and life off the reservation) because he felt a need to be back saying,

I guess, as you get older and wiser...you want to teach [the youth], be an example to your younger generation that you can have both... Yes, you can go off the rez, get an education and come back and there’s nothing wrong with that. Things on the rez will still be the same. The only difference is that you bring back something to share with everybody.

The social worker who also identified as a mental health specialist was 53 years old. She commented that being raised on the reservation, “seems like you are stuck, seems like there’s no way out...I thought going to the city was a way out for me, so that’s what I did, education was a way out.” Initially, she studied accounting, but then changed degrees and divorced her alcoholic husband. She began studying social work to have greater self-awareness, a good job, and a better lifestyle that would bring her back to the reservation. She left and returned four times to the reservation before she finally stayed. The back and forth and hesitation to permanently return was because she “didn’t really want to experience anything; the poverty, limited resources, housing issues.”

She was interested in helping people work on their relationships, particularly domestic violence issues. She found there was a need on the reservation for domestic violence group facilitators and educators. She facilitated a group for women. Based on her own experience with issues of co-dependency, she had a greater understanding of what the women were going through in domestic violence relationships.

The fourth of the social workers was 59 years old and also specialized in mental health counseling. She explained how she entered the social work field saying she always had interest in anthropology and archaeology but there weren't a lot of jobs related to those fields. One day "a friend of mine said 'you can go to school for social work...you help people.' I said, 'that sounds noble' and somehow the ball started rolling from there." She had worked in the behavioral health field off and on for over 20 years. At the time of the interview, she had an interest in becoming a history teacher. She loved history, read historical novels, had experience as a substitute teacher, and thought she would be a good teacher. She had all of the credentialing she needed for her teaching certification, with the exception of student teaching hours. She said money issues delayed her pursuit.

The graduate student intern in mental health counseling was a 38 year old Navajo woman. She began studying nursing because she enjoyed helping people, but changed her mind after a visit to an operating room. Then she studied journalism but transferred to school counseling. She worked as a counselor nine years at a high school and one year at an elementary school. She felt overwhelmed. She said,

It's so hard trying to push these kids who have no dreams, no hopes...not wanting to go anywhere, just thinking 'a high school diploma is all I need to be successful in life just because my parents did that too'...I've had so many [students with] behavioral problems...I want to focus...on the problem in a clinical setting...For that reason I shifted my career to mental health counseling.

In addition to her academic training in mental health, she also apprenticed with her father, who was a medicine man.

One of the school counselors had little to say about what interested her in school counseling, instead she commented on her experiences as a school counselor in Chinle. She worked at Chinle Elementary School, was of mixed European heritage, and was 64 years old. She followed her sister to the area more than 20 years ago. At first, she was a teacher and then eventually became a school counselor. She reflected on the challenges as well as positive aspects of working with a population outside of one's ethnic group or culture saying that at times people would not seek counseling from her because they wanted to speak with a Navajo person. Other times she found that, "people come in and [seek counseling from me], because they don't want [the conversation] to get back through their clan...sometimes it is safer...people come in here and [talk with me] because...[I don't] know uncle Albert."

She also commented about some of the disadvantages and nuances of working outside one's culture or ethnic group, including indirectly and unknowingly participating in the assimilation process, or endangering the continuance of certain cultural traits by offering services cross-culturally,

I learned to love the class and they loved me but it was a struggle. A lot of the kids came to school speaking Navajo. Their parents enrolled them in white people's classrooms because [they] wanted them to speak English well, by a Native English speaker. The process of that going back to the 80s and 90s is ...the kids that I first started with may be the last ones who could speak bilingually.

The other school counselor interviewed worked at Chinle Junior High, was Navajo and Mescalero Apache, and was 43 years old. He had, "an awesome school

counselor in high school.” He never really considered counseling as a career but just knew his school counselor was “an awesome lady with an awesome job.” His undergraduate degree was in art education. He had his certification lined up, but could not find a job in Chinle.

Suddenly, an opportunity “dropped in my lap, a fully paid scholarship to go to San Diego State University to study school counseling.” He hadn’t thought about returning to the reservation for work, and had been hired to work at Sherman Indian School in Riverside, California upon completion of his degree in San Diego in 2005. His old principal tracked him down through his mother and convinced him he was needed and should return to Chinle. He said that ultimately, “I always knew I’d work with Indian kids, I wouldn’t have it any other way... Seems like an innate calling.”

**Personal identification.** Each of the Navajo participants grew up speaking Diné/Navajo. Navajo was their first language, English was their second language and was learned in school. The male school counselor who identified as both Navajo and Mescalero Apache, (Participant 12), spoke Navajo, English, some Apache, and a little Spanish.

Most of the Navajo participants were raised on or near the Navajo Reservation; often each spent a few years living off the reservation in nearby metropolitan areas of the four corners region, such as Flagstaff, Phoenix, Salt Lake City, or Tucson. Many attended Bureau of Indian Affairs (BIA) boarding schools. Some moved off the reservation or out of state (Utah, Colorado, or Southern California) to live with Anglo families (part of Mormon placement program or foster system), others grew up in a rural area, sometimes in a traditional hogan. Early in his life, Participant 12 moved to housing in Phoenix

provided by a BIA relocation program. Each of the Navajo participants' environments in which they were raised were common for their age group among Navajos living on or near the Navajo Reservation.

Four of the Navajo participants lived most of their lives solely in one of the states within the four corners (New Mexico, Arizona, Utah, Colorado); the other three lived in the four corners as well as other states (Oklahoma, Nevada, Alaska, Montana, Washington, and California). Participant 10 had lived in Canada for work and Mexico with an exchange program while in college. Participant 7 had spent some time in Mexico with her foster parents.

A few of the Navajo participants identified themselves as bi-cultural or as living in two different worlds; this is a common phrase used by many Native Americans to describe the difficulties faced in embracing or existing as a member of a Native American tribe while simultaneously adopting or assimilating "white or western ways" into daily life. Sometimes living in two worlds can be an emotional and spiritual struggle as well as a source of tension within a family or between tribal members, and can have a major effect on the well-being and sense of identity of Native Americans. Participant 8, who grew up mostly off the reservation with an Anglo family "felt lonely" and was "not able to be fully back [to the Reservation] due to the way [he] was raised."

Due to past injustices done to Native Americans by European colonizers, living in two different worlds may also require coming to terms with historical trauma. Native Americans often have diverse opinions about the cultural appropriateness of contemporary Native American traditional practices. The debate arises from deciphering natural evolution of traditional ways of tribal life versus practices that were created or

developed as part of policies of assimilation and forced adaptation to globalization; in other words, identifying whether the current traditional practices are autonomous to Native American people or created in part by the dominating society. Maintaining a Native American identity can be a source of tension among tribal members. Questions and self-reflection involve whether one is adopting certain cultural traits because it was forced, or because it is a natural state of being and part of one's personality. Many Natives question whether globalization is part of healthy human evolution or oppression and how does a person honor his or her ancestors, culture, and still thrive in today's world. For individuals in a culture with a history of being dominated and oppressed through genocide, forced cultural extermination, and forced political dependence, self-identification is complicated and can have a major impact on a person's family life, well-being, and sense of self.

The six participants who identified largely as mixed-European descent grew up speaking primarily English. Three of the six participants were exposed to other languages as well. Participant 1 reported a Hispanic background; his father was from Northern Mexico and mother was from Cuba (with most of his ancestry leading back to Spain and the Canary Islands, with the exception of a relative of Mexico indigenous heritage). English was encouraged by his parents as his first language, but Spanish was also spoken in the home. Participant 5, who was raised in Aruba, was accustomed to hearing Spanish while growing up, and learned a few words. Participant 2 was accustomed to hearing Yiddish words, in addition to English, while growing up; this was associated with her Jewish heritage from the paternal side of her family. Each of the six non-native

participants spoke at varying levels more than one language, including a few words of Diné/Navajo as well as Spanish, German, French, or Greek.

All but one of the participants of mixed-European heritage were born in the United States; the exception was Participant 5, who was born and raised in Aruba. Participant 2 was born and raised in rural California and had lived in several parts of Europe; including the attendance of boarding school in England. Participant 1 grew up in a small town in central Texas; Participant 4 grew up in a small town in Oregon. Participant 3 grew up in a rural Mennonite community in Kansas; the final of the six, Participant 13, grew up in Ohio, in what she described as “middle class America.”

Each of the six mixed-European heritage participants had lived in at least three other states that were not in close proximity (Ohio, Alaska, Oregon, Texas, Kentucky, Indiana, Illinois, Maryland, Pennsylvania, Kansas, Alabama, Georgia, New Mexico, Arizona, California, Louisiana). Three of the mixed-European heritage participants had lived outside of the United States at some point in their lives (i.e. Europe, Aruba, The Chaco at the Paraguayan/Argentine border, Grand Cayman).

Roughly, the same number within the two groups had travelled throughout the United States. Most of the Navajo participants who travelled outside of the United States stayed on the North American Continent, with the exception of Participant 12, who went to Belgium as part of a Junior High program. The mixed European participants collectively had travelled to Europe, Mexico, Canada, South America, China, or the Caribbean.

**Cultural identification.** All of the Navajo participants alluded to or identified as being bi-cultural or living in two worlds, the Navajo traditional world in which they were



raised and the western professional world they entered when they earned their professional degree or attended western influenced schools during childhood. A few identified as being traditional because they practiced traditional Navajo beliefs, spoke the Navajo/ Diné language, and attended ceremonies. Some felt they were not traditional and that really only a few traditional Navajo were left, mostly the elderly; they defined the term 'traditional' as meaning to live, as well as speak, in the ways of tradition. This included having no electricity or running water, living on the reservation, raising animals, dressing in traditional clothing, speaking Navajo, going to a medicine person when ill, observing traditional customs and spiritual beliefs as well as participating and attending ceremonies, and living a life closed to outside influences. Traditional beliefs were thought of as unchanging, or having a very slow evolution through time within a culture.

Western culture was defined by the European mixed and the Navajo participants in the same way with a few exceptions. The concept of western culture was defined by the majority of the participants as generally having European origins. Participant 10 included parts of the Middle East, Egypt, and the orient became part of the definition of western. Participant 13 regarded western culture as America in the context of the rest of the world. Participant 1 thought of Canada and Latin America in addition to the United States and Europe, but to a lesser extent, as western culture. Participant 2 summed up western culture as "white, European, American."

The consensus of participants felt western culture was subject to change and through time, beliefs from multiple different cultures and regions around the world would be incorporated. Participant 4 gave the definition of western culture as being "an amalgamation of religious beliefs and values, better defined as non-traditional, being

influenced by multiple groups.” Participant 11 summarized the concept of western culture with one word, “global.”

None of the European mixed participants thought of themselves as being traditional. Participant 3, who had extensive training in psychiatry and medicine, viewed himself as “western scientific,” though he was raised in an Amish Mennonite agrarian community. Participant 13 viewed herself as “apple pie American.” The extent of her ties to the concept of being traditional included being related to 2<sup>nd</sup> generation Italians who made ravioli and German farmers who made sauerkraut and dumplings, yet she questioned whether she would be considered “modern.” Participant 1 viewed himself as being assimilated; he was of Hispanic heritage (primarily originating from Spain and the Canary Islands) and his parents moved from Mexico to Texas with the purpose of “becoming American.”

Participants 5 and 8 did not like to think of themselves on continuums of traditional/non-traditional, indigenous/non-indigenous, main-stream/modern, assimilated/acculturated. Participant 8 said, “I am my own planet...my own family doesn’t understand me...people give me a hard time thinking that I am thinking I am better than them due to my education.” Participant 5 said he was “normal, comfortable being myself, not labeled.”

**Religious/Spiritual beliefs.** Most of the Navajo participants identified themselves as raised with traditional Navajo beliefs of creation, deities, and spirituality. In addition to traditional Navajo beliefs, many were also raised with Christianity, Catholicism, Mormonism, and the Native American Church (NAC). Sometimes non-traditional Navajo

beliefs were forced upon the participants when they attended boarding school, or indirectly through foster families.

Two of the participants reported having traditional healers in their families. Participant 6's father was a medicine man and alcoholic. His alcoholism affected her family adversely and altered her perceptions of traditional Navajo beliefs. As a teenager, she left to live with a Mormon foster family in California, and adopted some of their religious beliefs. Participant 9 told a story about a Navajo friend's reason for joining the Mormon church. Her friend had told her, "I went as a little kid. They had the best candy. So, I went." The friend initially attended the church not for the philosophy or spirituality it offered, but rather for the candy.

Two participants adopted their own approach to spirituality, Participant 8 took bits and pieces from Traditional Navajo, NAC, Catholicism, and Mormon belief systems to which he was exposed, and created his own belief system. Participant 12 explored several religions, but developed his own sense of spirituality that embraced and respected nature as well as the environment. A few of the Navajo participants attended spiritual events of multiple religious or spiritual approaches to life, such as taking part in traditional ceremonies as well as attending NAC meetings.

All of the participants of mixed European heritage had been raised with some form of Christian beliefs. Participants 1 and 5 were raised Southern Baptist, but neither maintained their beliefs borne from the exposure. Participant 1 explored different religions, including Buddhism and Sufism (inspired by the Persian mystic Rumi), while attending medical school. Participant 5 considered himself Christian and was a member

of Community of Christ Church, which was “more closely fitting to [his] view of creation.”

Participant 13 grew up with fear of her childhood religion, associating the notion “children should be seen and not heard” with the strict Lutheran church life she experienced. She considered herself Christian, and believed in a higher power, but did not belong to a specific religious sect or church. Participant 4 was raised Protestant. As a child, he attended a Mennonite Church, influenced by his Mennonite heritage on his father’s side of the family. At the time of his interview, he was attending Grace Bible Community Church.

Participant 2 asked, “Is there such thing as a religious nut?” She was raised Roman Catholic but at age 18 became interested in the Goddess religions which she thought of as “a distillation of European paganism mixed liberally with New Age philosophies.” She developed a deep love and respect for nature and its cycles, but did not like the spell casting aspects of the Goddess religions. The two primary religious philosophies she followed at the time of her interview were Tibetan Buddhism and Core Shamanism (born from the research of American anthropologist Michael Harner.)

Participant 3 was raised with “old school, traditional” Amish Mennonite beliefs; however, at the time of the interview, he considered himself agnostic and “not prescribing to any firm religious conviction.” He believed in a creator and was open to religious and spiritual teachings. He credited his liberal arts education as an important influence that expanded his thoughts and beliefs regarding religion and spirituality.

**Definitions of mental health/illness.** Understanding the similarities and differences in staff and client perceptions and concepts of wellness, mental or behavioral

health, normality and psychopathology are crucial when analyzing the possible benefits of a particular form of therapy, in this case, art therapy. If concepts of wellness have major variability then a common language is first needed to be established before therapeutic services can be offered in an effective manner or new services, such as art therapy, can be fully integrated with cohesion and staff consensus. Perhaps art therapy can be part of the process in finding a common therapeutic language for staff and clients alike due to the universality of art making and symbolic expression.

The overall difference in definitions of mental health and mental illness between the Navajo staff and mixed European heritage staff was an “insider” understanding of the clients’ perceptions regarding wellness that came from being part of the same culture, growing up with the same beliefs or growing up around people who had the same beliefs. This “insider” belief was sometimes in addition to or paralleled with understanding formed from philosophical deliberation, spiritual exploration, and an adaptation of definitions learned in academia but altered through professional experience. Some of the Navajo staff, who identified as being traditional, intertwined Navajo concepts of balance and harmony, maintaining a positive outlook come what may, with definitions learned in academia. For some who were more traditional, mental illness did not have a genetic basis rather, was influenced by the mindset and environment the person was born and continued to maintain throughout her life. Ceremonies could negate the imbalanced behavior. Many of the mixed European heritage staff also had concepts of mental health and well-being that related to spirituality and one’s daily life in addition to academic definitions. An indigenous ethnic cultural component was missing in the definitions coming from the participants of mixed European heritage. The staff who had attended

school recently tended to define mental health in more academic ways. They often used terms from the DSM IV-TR and acknowledged the role of genetics and other scientific methods at length, in determining the origins of mental illness.

The participants reported many clients visited the behavioral health department only one time and never returned. The junior high school counselor summed up a common assumption that many people on the reservation have about the behavioral health department affecting the underutilization of services. He said,

The perception of mental health a lot of times still is convoluted with all kinds of crazy ideas...People might be resistant to using that service they don't understand; yet once they connect to it, it's not that black and white. I think they would be pleasantly surprised, if they walked into [CCHCF Behavioral Health Department]...They are not going to be put in a straight jacket or be given a frontal lobotomy or whatever ideas they have.

The junior high school counselor gave his personal definition of mental illness saying it is “an imbalance somewhere in that person’s life, and I view it from my Navajo, Navajo-centric side...not to see it necessarily as a detriment, or as an illness, or as a deficiency in somebody.” He continued saying that helping clients would involve them “regain[ing] some equilibrium with nature, with the environment so [they] can function at some level and help contribute in some way to fit back into [their] culture or [their] community.” He utilized the eco-systemic approach when identifying mental illness that he had learned at San Diego State University. He described his approach saying that at birth, “there are these issues [children] are born with... it’s never just the child, it’s all

these different things that are coming into that child, connections...from everywhere that must be looked at, in order to help that child.”

He defined a balanced person as one who develops within the normal range of markers for human development. That person will have supportive family, friends, and mentors in place who contribute to that person’s life in a positive way. As a child, he or she will have the protective factors of a good family life, environment, and health. In contrast, a child who experienced risk factors, such as a household with a struggling single parent not available for the child, or a household with domestic violence or alcoholism may develop mental health issues.

The elementary school counselor felt there is sometimes a genetic basis for mental illness and the environment played a big part as well, in what creates mental health issues. She acknowledged that often she was able to witness behavior in the students that CCHCF staff might not, when a student was referred out to the hospital. The students might have acted very differently in an office setting than among their peers. She felt being witness to “their world” gave her an advantage and insight into what was happening.

The male medical social worker utilized what he had learned during years of experience in social work to conclude that, “Every person comes with four parts, the social side, the mental side, the physical side, and the spiritual side.” Good mental health meant a person was, “in-tune with every aspect of all their sides...so, as a whole you are able to function.” He thought that mental illness came from many different origins, “You were born with it, you have a hereditary pre-disposition for it, or from psychoanalytic

theory, [you] are here now and if [we] look back at your history, maybe the course of events lead up to you having this.”

He said that people on the reservation don't talk about mental illnesses, if they did there was a “spiritual explanation for it.” He didn't think there was a word for mental illness in the Navajo language. He gave an example of how a person exhibiting what is called a mental illness in western culture would be treated in traditional Navajo culture. “Everybody in our culture, as a family unit, are able to take care of themselves [and would] take care of that person.”

He reflected on how adopting western ideas of psychopathology versus Navajo or Native ideas of balance and imbalance affected people saying,

I see that today, [if] somebody's depressed ‘oh, there's something wrong with you.’ There's that negativity...back a long time ago it wasn't seen that way...It wasn't until recently when people were influenced by western thought that ‘oh that's what's wrong with Johnny over there, he's got schizophrenia or he's depressed...Now, it's people having problems.

He regarded the negativity as society “segregating folks.” He thought the shift in adopting ‘western’ models of thinking was what prevented many people from utilizing the services at the CCHCF Behavioral Health Department. He commented, “People don't want that [to be diagnosed or labeled]. They don't want to be seen coming in here. A lot of times people will ask if there's a back way to go out.”

The medical social worker/mental health specialist believed that “everything diagnosed in the DSM” was representative of mental illness. She explained further that, physical, mental, emotional, spiritual aspects of a person were all connected and must be



in balance to maintain mental health. What a person did, thought, felt, and believed interacted and affected each other.

The medical social worker/mental health counselor viewed mental health as being, “the working of the mind, emotions.” She continued saying when viewed from a social work perspective mental health would include “cultural and environmental” factors. She attributed many of the mental illnesses prevalent at the clinic as having biological origins, saying, “The hormones aren’t kicking right, or there’s chemical imbalance.”

The social worker supervisor early in her training viewed the definition of mental health as involving psychiatry, psychology, but due to the use of the term behavioral health, “has broadened the definition.” She explained that traditional Navajo view mental illness as, “when things get off balance, and when there are things you can’t see that are happening to you.” Rather than seeking out a therapist or seeing a need for psychoanalysis, the traditional person would go to a medicine man or woman and have a traditional ceremony done. She said that mental illness happened, “when you have a certain belief and you violate those.” Explaining, “It would really bother me, it would affect me in everything I do until I go and try and have it fixed.” She gave an example that in addition to violating taboos that bringing things “into your life that you don’t necessarily have to have...like alcohol...are some of the kinds of things that can be destructive and throw you off balance.”

The substance abuse counselor/mental health specialist felt that, “Mental health has to do with the mind...Is it positive or is it negative or is it stable...is it balanced?” Traditional Navajo emphasize positive thinking, they don’t concentrate on bad things that

may be, rather ones focus should be to find the good in life. Regarding the origins of mental illness, she said,

Sometimes [mental illness is] related to witchcraft...only certain people...will be blessed with hand trembling or crystal gazing. We can't say, 'I want it'...It comes automatic, naturally. So some [people] don't know anything about traditional [Navajo beliefs] and when they get that blessing, it comes in the form of anxiety, chest pains, squeezing, hands are hurting. 'Something's wrong with me, I'm scared.'...The same symptoms of anxiety happen to this individual when they get their blessing and they don't know how to deal with it. It's just a matter of what they believe and what they want to do. If you don't take care of it you are going to be like that until you decide what you want to do.

She had a more traditional Navajo approach to the concept of genetics or predisposition and psychopathology saying, "Through our teaching we are supposed to remain positive." She gave an example of how a person's "mental health" can be affected from the point of conception. She noted that traditionally, a person should be thinking, "Our baby's going to be healthy and fine." Problems or imbalance comes about when a person is "thinking negatively...that's when you are affecting the baby's body, mind, and spirit." Prevention of an imbalance is taken throughout a pregnancy with, "ceremonies...so things will be positive...lay down the groundwork and the path of the baby."

The graduate student intern of mental health counseling thought, "Mental health is the well-being of a person's mind." Her views on mental illness were, "It could be

behavioral disorders...different kinds of personality disorder[s]...It could be genetic or...[something] traumatic in a person's life...or attributing medical conditions.

The clinical psychologist, age 54 regarded people as having many aspects that contribute to well-being. He said, "We are a physical people. We are spiritual people. We are cognitive. We are social. We are creative." He then defined the origins of mental illness commenting, "Psychopathology is when those five particular domains of our life are not being valued, honored, and pursued in a reasonable, appropriate fashion." He gave an example saying that PTSD (Post Traumatic Stress Disorder) "is a failure to cope...The events and circumstances of life have exceeded the individual's ability to deal with the stress that those life events [caused], as well as the social environment that hasn't been able to support [the individual.]" He also said that, "psychoses have a genetic process...a neurology that we inherit. There's this interplay of psychopathology that is both individual [and] interpersonal...Interventions in a person's mind can affect the biochemistry of the individual and change the way we feel, think, behave, act."

The clinical psychologist, age 68 regarded mental health as, "the state of thinking and behaving that brings satisfaction to a person." He thought the way in which people learn to think about behavioral experiences or history affects their ability to cope, and whether or not they develop mental illness. He explained, "Are you able to overcome all of the irrational beliefs you have acquired growing up?" He believed how we were taught to think about the world is also affected by "genetic bases for disturbed feeling, tendencies to have feelings positive or negative...distorted imagery, [or] tendencies to distort your interpretations of things."

The CCHCF Behavioral Health Director and child psychiatrist thought of mental health as “the ability to love work and play” and mental illness as the opposite, when a person is “not able to love work and play.” He gave a more scientific explanation using the leading theories on how mental illnesses develop saying, the origins are from “combinations; environment and genes...All of us probably have [a] gene that predisposes us to something: anxiety, panic attack, depression, to dissociate...[An] environmental stressor...interacts with this gene to create an expression of mental illness.”

The psychiatrist also trained in psychotherapy, Core Shamanism, and music therapy said, “Mental health is the state in which a person is able to respond flexibly to life, accept their emotions, and be in relationship with themselves and others and do something meaningful to contribute.” She said that using the term “Mental health, is a misnomer because it implies only your thoughts are healthy instead of looking at the whole person.” She preferred incorporating emotional, spiritual, and physical aspects of a person as well. Regarding a definition of mental illness she said,

I tend to lean towards a mental illness as something that is biochemically wrong. There’s not enough serotonin or there’s too much dopamine... We have sort of lumped together, in psychiatry, illnesses that are primarily neurological...with somebody whose upbringing was severely hampered by trauma, concepts of themselves and others... Where is a problem more of a life problem? A spiritual problem? An existential problem? ...Where is that line?...It is a question of a spectrum...It’s not black and white.

The psychiatrist age 59 approached mental health as stemming from, “a sense of well being.” Rather than label people with different psychopathologies, he believed “the goal in life is to accept ourselves as we are, with reactive moods, with inadequacies, with spiritual strengths, and spiritual weakness.” He commented when understood holistically, one must examine the “bio, psycho, social, [and] spiritual etiologies” of mental illness. He said society often overlooked “the historical, the structural, and the individual traumas that people experience that contribute powerfully to psychopathology.” He gave an example using the resulting cultural impact from the injustices done to Native Americans “who were mistreated in the colonial era...misunderstood in terms of their worldview, subjugated in terms of their life ways...That is a powerful determinant of lack of well-being which we could call psychopathology in the present day.”

**Understanding of treatment team.** The staff’s understanding of one another and the specifics of each provider’s services in a behavioral health department, aid in staff cohesion, which ultimately affects client outcomes. All of the participants had a good idea of the roles and services each staff member provides, including their own. Most regarded the clinic service structure at CCHCF Behavioral Health Department as “integrated,” with staff “overlap” in duties. The staff of mixed European heritage had the highest level of academic degrees, having spent more years in academia. They tended to acknowledge or emphasize greater differentiation of services provided and skill set among staff based on one’s profession. Many of the Navajo staff reported little variation between the actual services provided to clients; professional titles were de-emphasized or irrelevant to staff/client interactions and outcomes. The Navajo staff differentiated capabilities and duties from the mixed European staff in relation to cultural competency;

their ability to integrate traditional Navajo concepts into the services offered and the ability to communicate effectively in the Navajo language. In addition, better working relations may have developed between the Navajo staff and Native Medicine staff, as well as with patients coming from traditional backgrounds and those who employed greater integration of traditional Navajo concepts versus staff who maintained western approaches to therapy and philosophical life concepts.

The junior high school counselor felt his studies at San Diego State University set him apart in the field from most, specifically regarding his training in diversity. He commented on how the multi-cultural part of his education helped him “to understand how multi-faceted people are.” Prior to his training, he had this idea that “we are 99.9% Navajo at the school, and it’s like a cookie cutter for everybody, but no, these kids who are 99.9% Navajo are just as multi-faceted as the kids at Mission Bay High School [in southern California].”

He appreciated working with the Behavioral Health Department at CCHCF saying, “I need IHS, I feel my connection with their department is vital, and without them, I think we’d be losing kids.” Sometimes the eco-systemic approach he used was not enough to help his students. He could then always rely on the clinical expertise at the Behavioral Health Department.

He gave an example of the conflict that is present when trying to help clients who have the mentality of only using traditional methods offered by a medicine man or woman but are in need of help from CCHCF Behavioral Health Department. He said, Let’s think about how to help this person and bring in as many resources as possible. Yes, let the medicine man be one of them. It all goes back to the risk

factors that contributed to what this kid is doing. Those risk factors are always beyond what can be done by a traditional person to alleviate...We had a young lady come into school one morning and cut her-self right in school. She cut herself pretty bad. Because she was a self injury, they took her to the emergency room.

The trouble arose when one of the psychiatrists from CCHCF Behavioral Health Department met up with the patient's family and his services were refused. The junior high school counselor continued,

She came back to school the very next day and I knew she was not ready to come back...not with the emotional state that she was in the previous day. I called the grandma back in and I told her 'Are you sure? This young lady just went through this very big ordeal and I don't think she belongs back in school yet.' With some encouragement to look at things differently and explore all the options she agreed to let [one of the CCHCF psychiatrists] see her granddaughter.

The junior high school counselor said that the grandma and student went to the behavioral health department and the psychiatrist did an assessment, finding that the young lady needed intensive care. She was determined suicidal and a danger to herself. Rather than being admitted to inpatient care immediately, the grandmother requested the student be allowed to go home that night and return to the clinic for care the following morning. The student never returned to the clinic. The behavioral health department was told she was taken to a medicine man. The junior high school counselor was uncertain whether the family followed through with any type of care for the student, he felt that,

The young lady never got the help she needed...In those instances when the family

perspective about counseling are skewed then it's a problem and you have to be really sensitive to that and understand how you can talk with them, present it to them in a way to try and make them feel better about it.

The junior high school counselor's story reflects upon the necessity of integrating context of who the service provider is in relation with the community one works. The psychiatrist had a level of expertise from academic training, but could not persuade skeptical clients to utilize his services. Some clients need a person whom they feel comfortable, who speaks the language, is of the same ethnic background, to help them feel comfortable seeking services at CCHCF Behavioral Health Department. Professional titles become meaningless when clients are apprehensive about the behavioral health field and non-Native service providers.

The elementary school counselor integrated coping and social skills promoting socialization and communication with others, and the use of 'I' messages into her work with students so that they could function in the classroom. She also gave students tools for controlling anger so "when they get into snit-fits" they were able to deep-breathe or calm down. She met with students individually and in groups. For problems that were more involved than the ability for daily functioning in school, she referred students to the CCHCF Behavioral Health Department, more specifically to the department director.

The medical social worker felt his training focused on the importance of listening to people. He also felt there were advantages to being of the same culture as your clients. He said,

The key thing is being able to listen and to talk to them [clients] in their own language...It also falls back on your up-bringing. A lot of emphasis is on Ke'



[traditional Navajo kinship system to maintain family unity, respect, and cooperation]. Most people use Ke'. I think that's the break-through that most people use in terms of introducing yourself and who you are in terms of your clan. If I feel like it's going to help me with a patient, build rapport, I'll do that. In regard to his perceptions of the other staff members' roles in the behavioral health department he stated,

I believe they are more into the mental health aspects where they are dealing with depression, anxiety, how to treat them, whereas a social worker you don't get that kind of in-depth training about actually doing therapy... You do psycho-social assessments. It's not counseling, you're just asking questions, getting a better understanding of where folks are coming from... The basics, the fundamentals of what we, [the behavioral health staff] do is the same... There is a lot of overlap. I tend to do more than I'm supposed to.

He said in the past few years he learned more about the mental health and counseling side due to the overlap and was then "able to do a little bit more for the patients" than he normally would.

The medical social worker/mental health specialist viewed the social work aspect of her job as "more like a band-aid" she would "refer [clients] out, connecting them with resources." If a client was "just coming in, talking about the social end, I will do social work, but if a patient has an appointment with me... then I become a therapist, more working with their issues, their emotional issues... I juggle both [fields]."

The medical social worker/mental health counselor regarded social work as using “what people already have.” She emphasized the importance of her role in the clinic specifically in relationship to the clients saying,

It’s more appropriate for here. We work with medicine people... We use what people believe in. We have medicine people on staff here, and we refer... If they use herbs, we use herbs. If they use a ceremony, we use ceremonies, whereas a psychologist, they’re kind of like, ‘that’s kind of out of our field.’ That’s how social work is unique. We take what’s already out there and don’t impose a lot of stuff.

She then explained several nuances of working with the Native Medicine staff and other Medicine people giving an example of how her cultural background and understanding helps saying,

There’s good medicine people and bad medicine people. So if you go to a bad one, they might ill-advise you and it wouldn’t work. There’s quackery going on in the Navajo, the medicine profession. So you just have to know who they are... We have a Medicine Man Association now that people can join. They have plaques on the wall, that they’re a member of the Medicine Man Association. If [a medicine person is] miss-practicing you can report it to them [the Medicine Man Association.]... I just heard stories that people have been healed from mental disorders... [such as] soldiers that go to war, [and develop] post traumatic stress disorder. There’s a ceremony for it... There’ve been people who’ve been cured, but those ceremonies are very expensive.

Regarding the duties of other staff members, she thought, “The psychiatrists, they do medical kinds of things, [such as prescribing] medication... A psychologist does a lot of testing, like if the courts ask him to.” She commented on the uselessness of projective testing on the Reservation, “I don’t even know how valid those things are for poor people out here...those were developed for the middle class white people.” She categorized those trained in mental health as working “with mental disorders.” She concluded that, “social workers here, we work with everything, including mental disorders.”

The social worker supervisor made a comment that in addition to regular social work duties such as case management, discharge planning, and referrals for medical services that,

Here [CCHCF Behavioral Health], since we are integrated, we get a chance to do one on one, you can do group, you can take on cases and do counseling too. So it’s pretty much open...There’s some overlap...It’s kind of like a training program.

She continued saying a social worker,

would cover the mental health, social, and maybe substance abuse and be able to provide whatever services that patient needed plus a nursing home placement. If it was a mental health specialist they wouldn’t know [the] first thing [about] where the paper work is going to start.

The substance abuse counselor/mental health specialist said that about two years ago during a departmental check, it was found that CCHCF Behavioral Health staff offered services to over 600 clients for that year. Her role in the process was to do alcohol intake and evaluation. She said,

I have groups going, especially the ones who are first offenders, if it's the first full week on substance abuse we try...to run them through the five-week session and see if it helps them. If they return, and it didn't help them, or they have a positive drug screen, then we consider rehab.

On the side, she also helped do intake and evaluations preparing clients for meetings with the psychologists or psychiatrists. She said there was a lot of overlapping of duties and staff works together helping each other. In reference to other staff she said,

After an intake is done, [the psychologists] go in and do their psychiatric evaluation and then they come up with...a diagnosis and a treatment plan...If they've seen a family and they need intervention, sometimes they will say 'can you come in, help me?'...I help with family intervention... group intervention, group activities.

Even though the graduate student intern of mental health counseling was not actually on staff, she commented on how she intended to use her current training, including both academic and traditional Navajo medicine with her father who was a medicine man. "I want to bridge [the gap between traditional medicine and western psychology methods]." She wanted to create something new by incorporating "the Navajo/Diné medicine or healing into counseling." Her ultimate goal was to start her own private practice utilizing traditional ceremonies and mental health counseling techniques.

The clinical psychologist, age 54 categorized each staff members' typical roles in a behavioral health clinic saying,

What [the psychiatrists] offer is expertise in their pharmacology. What the social workers offer is their expertise in [finding] resources and connecting the patient

with the resource. My role as a psychologist emphasizes...dealing with the interpersonal...intrapersonal...The stuff going on inside the individual that is creating the unrest, the lack of motivation, the circumstances that are preventing them from experiencing life in a reasonable, healthy, meaningful manner...

Psychology traditionally has been [a field] of assessment...using objective and subjective assessment tools ...In this particular context, it's not something that we do excessively because of the amount of time that it takes and the greater burden that we have to carry in seeing patients.

He commented on problems that could arise when incorporating multiple disciplines and belief systems at a behavioral health clinic. He gave an example of a conflict that occurred between his western approaches working with a patient versus the medicine man's traditional approach. The patient had come to CCHCF for help dealing with his anxiety about going to school. The clinical psychologist reported the patient's anxiety developed out of fear that his mother and father would be harmed while he was away at school. The clinical psychologist continued talking about the patient saying,

He was afraid about what was going on with his mom and dad, for good reason.

They were doing things that weren't wise; unsafe. One of the things that he was very good at was basketball. It was one of the tugs that caused him to want to go to school. It was also an area of self-efficacy and self-accomplishment that he could engage in.

When this same patient went to a traditional healer the clinical psychologist said, "He got a completely different diagnosis." The psychologist and traditional healer had opposing

methods to help the patient with his anxiety. In this case, the psychologist backed off because he felt,

It's up to the family, then, to make their decision and what they are going to do, to follow the practitioner that they want to see. I didn't feel comfortable intervening with what the traditional practitioner was saying. In my gut response, I don't think he was accurate. From his perspective, he didn't think I was accurate... To continue to engage in basketball from my perspective was a self-efficacy issue. It was a social support system. It was a way to get back into school. For the traditional healer, the basketball process was tugging on his intestines, and the pulling of his intestines was creating the unrest in his system and he needed to stop that.

In this case, a compromise was never made between the opposing theories of the clinical psychologist and the traditional healer to help the young patient. The psychologist didn't know how the situation could be resolved other than by making a choice between the two methods. He said the situation "was very difficult for the young boy." Unfortunately, neither service provider, the medicine man or the clinical psychologist, were able to find a common approach and work together to help the client. This scenario is not unique regarding cross-cultural issues that can arise. Perhaps the use of art therapy as both western medicine and traditional healing honor the power of art as a therapeutic tool, can provide a resolution and bridge for these types of situations.

The clinical psychologist, age 68 viewed the role of a psychologist was to focus on behavior change through evaluation of both one's actions as well as cognitions. He thought that a psychiatrist comes from the allopathic medicine direction, focusing on

behavior as well as biochemical abnormalities. He said the mental health specialists and social workers helped to guide patients into healthy behavior. He commented that,

They [mental health specialists and social workers] don't have the training to understand the dynamics that underlie behavior; how behaviors [were] acquired, what is it cognitively, mentally, that maintain those behaviors, and how those variables have to be changed to produce different behaviors.

The CCHCF Behavioral Health Director and child psychiatrist said in his training there was "a strong emphasis on technique; a strong emphasis on forming an accurate formulation of a person's problem." He had "an excessive amount of time working with patients who were extremely impaired." He said his training included,

A lot of immediate feedback...there would be people in the room with me observing what I did. I would be supervised very closely, scrutinized very intensely. I would be video-taped. Sometimes the video would be played to a group of people.

Prior to his training as a psychiatrist, he was a pediatrician, and learned a lot from the medical side on what is going on with a patient, including child development markers, whether a pattern of behavior is normal or not.

The psychiatrist also trained in music therapy and Core Shamanism talked about her provider role saying she did "mostly drug management," and,

I also have a couple of patients I see for psychotherapy and I talk to a lot of patients about their spiritual life and where are they with it...I don't talk about particulars. I talk about the interplay of existential despair and depression...I try to encourage them to find something meaningful for themselves, that's greater

than themselves...I look at myself as mostly being a witness to their work.

Sometimes I'm a sympathetic ear, sometimes I'm a scaffold if their own sense of self is faltering. I can be sort of an auxiliary ego to them, sometimes I'm a guide.

She gave an assessment of how a behavioral health clinic is run saying,

It's generally assumed that a psychiatrist or sometimes a psychologist will act as...a team leader. That is true...to a greater or lesser extent here. It is more individually propelled than anything else... [Social workers] have a foot in each camp. They have a foot in social services, housing, family safety, disposition after hospitalization, and they have the other foot in psychotherapy. Some choose to do more of one or the other. Here we have a mish mash. There was an attempt to divide it between mental health specialist and social worker but those lines are completely blurred...The team as a whole should work with the patients toward their best possible mental, emotional, spiritual, and physical health and not just work on little bits and pieces with band-aids.

The psychiatrist age 59, broke down the roles of the staff based on the treatment team he was working in saying, "I'm often put into the role of being the expert...I am more of a facilitator of helping Navajo individuals formulate solutions they feel comfortable with themselves rather than giving them [solutions]." He helped the clients who were struggling with being in two worlds to, "coexist with the western dominant culture on the one hand [and what it] means to be Navajo today on the other hand." His role also "might be prescribing a medication, it might be giving a technical recommendation to a judge."



He commented on who comprises the CCHCF Behavioral Health children's team and how they work together. He said the team consisted of four people, another child psychiatrist, the secretary, the child and family therapist and himself. He continued describing what each team member provided saying the child and family therapist have, "a lot more insight into just what works and doesn't work from a cultural perspective. I certainly find myself turning to both and any other of the Navajo staff...to understand what's going to be most helpful."

He brought up the issue of suicides in the area to use as an example of how understanding cultural context and relativity has been crucial when providing therapeutic services on the Navajo Reservation. In traditional Navajo culture, after a person dies, "you don't talk about the person." He explained,

The way that we grieve from a western perspective is specifically by talking about it and so when somebody comes to me and they're obviously grieving, and grief is part of the basic problem they're presenting to me, the only tool that I have is to talk about it. That's really the only thing I know intuitively to do to be helpful... How do you find inoffensive ways to talk about the basic issues you need to talk about as an invited guest in this kind of a context?... I often find myself talking with traditional healing colleagues or [the child and family therapist and the substance abuse counselor] or other people trying to figure out what can we do to be helpful here.

He commented on the reception his services have garnered by staff and clients alike saying,

At one level...I experienced a lot of gratitude. At another level...there is a lot of ambivalence about what Indian Health Service represents...There's a lot of history there...It's not far removed to see Kit Carson in me...When a Navajo person looks at me (and probably more so in a Navajo male than in a Navajo woman)... There are many, many undertones that make the experience much more complex than it appears on the surface...I try to use patient centered approaches that are based on informed consent...[and] to explain the pros and the cons for what it is I'm recommending. The longer time period that I have working with individuals the more we know and trust each other. Because I'm a white 'authoritative male,' many times [the child and family therapist and the substance abuse counselor] look to me to do certain kinds of things that seem to bring legitimacy by the fact by virtue of who I am...I look to them to help me to do that in the most sensitive way, but also to add integrity to what they're doing. Because what they're doing is also breaking with some traditions and expectations.

He gave an example of how he began addressing cultural sensitivities and the nuances involved while working on another project at a different facility by consulting with the Navajo staff there saying,

It's almost ten years now and during that time we worked together, we formed quite close relationships...My way is not to avoid these difficult issues but to talk about them when they come up and to talk about how they can impact here [CCHCF Behavioral Health] as well. Usually, at the point the issue comes up and it's raised, people are somewhat grateful...and there is an opportunity to talk about it...There are some contexts in which...the powerful colonial experiences

cannot be talked about... Say for example, the experiences of boarding schools or livestock reduction here on the Navajo Nation, or even going back to The Long Walk... I've learned... 'this is not the time to talk about that,' because it is going to be met with stony silence and even hostility... but there are other places that they can be talked about and people can share quite freely their experiences.

He emphasized that developing long-term relationships with Navajo co-workers was vital for developing cultural sensitivity with clients and establishing trust. He said, There's a deep sense of gratitude for the insights, for the sharing that can take place in that context. Without that, I could also be just a stranger that you have to be very wary of, not knowing what this person's intentions and objectives are and the implications of my saying something, because you are in unguarded or unknown territory.

**Art therapy.** Overall, the reception of the art therapy scribble technique and the idea of using art therapy with the patients and clients the participants worked, was viewed positively and worthy of introduction to the CCHCF Behavioral Health Department. Many of the participants said they were unfamiliar with the field of art therapy, but then gave examples where they had unknowingly been exposed, or were using art therapy techniques not identified as such. Some were sceptical about how the adult patients would react if they were asked to start drawing, or to use crayons during a therapy session.

Several participants, both Navajo and mixed European, thought art therapy might be beneficial for Navajo clients, due to the "artistic nature" of Navajo culture and the thought that Navajo beliefs and traditions are operating more out of the "artistic right side

of the brain.” One participant even noted the Native Medicine staff used client drawings as part of their assessments at times, saying that art therapy could be used to integrate efforts of the two departments. Some felt art therapy would be beneficial for clients who do not like to verbalize their emotions, or were resistant to western theoretical approaches to behavioral/mental health problems.

A few of the participants, mostly Navajo, felt there would be greater benefit in training existing staff in art therapy over hiring an art therapist as part of the staff. The Navajo Nation Department of Behavioral Health has a Navajo-preference employment hiring process. Many of the facilities both local and federally run, such as the Indian Health Services operated CCHCF Behavioral Health Department have difficulty finding long-term staff with the appropriate academic credentials and licensure. The Navajo Reservation is a vast area of land about the size of West Virginia and is sparsely populated. Chinle is located in a remote rural area, and for many people, especially those not from the area, is not a desirable place to live due to the inconveniences.

While I was interning as an art therapy student at the Navajo Regional Behavioral Health Clinic (NRBHC) in Shiprock, employees were encouraged to take additional continuing education credits in areas such as traumatic brain injury, or using the ropes course for addictions. The NRBHC constantly had guest speakers come, covering these types of topics in the conference room or provided opportunities funded by NRBHC, for additional training where staff was able to attend and earn certificates. Additional training to one’s academic or professional expertise was encouraged, likely out of necessity and lack of professionals interested in working long term on the Navajo Reservation. Due to the unique employment situation on the reservation, Navajo participants from the thesis

study likely had a different mentality about professional titles and academic degrees in relationship to actual services provided than their mixed European counterparts. This may have accounted for the belief that it was not necessary to hire an actual art therapist, but more productive to train staff in art therapy. In addition, the character of a person and what he or she can do for the community has greater value in traditional Navajo society on the reservation, where few people have formal education past high school. Often, a person with a professional academic title or form of expertise is viewed as someone to learn from, with the newly acquired skills being used within the community.

Most of the mixed European participants felt there would be additional benefit in having an art therapist hired on as staff, for more in-depth exposure to the field of art therapy. Even the participants who, without any formal or with limited training, reported using art therapy techniques with their clients felt it would be beneficial to have an art therapist on staff for consultation purposes and elaborate art therapy directives. The participants of mixed-European heritage tended to place a greater value on academic training and used professional titles to define a person's abilities at the clinic.

Several of the participants, both Navajo and mixed European, had previously experienced or witnessed using art therapy with children. Their perception was that art therapy was to be used solely with children and not for clients of any age. The participants' perceptions were much like other practitioners in the behavioral health field who pair the use of art therapy with children, undermining the legitimacy of using art therapy with clients of all ages and belittling the potency of the field. This perception of art therapy as a technique to be used with children may also have an effect on the

perceived practicality of hiring an art therapist at a behavioral health clinic with a multi-generational client base.

It is uncertain whether the participants were aware of the amount of education necessary, i.e. a master's degree, to be qualified as an art therapist. Many had been introduced to the field of art therapy via workshops. They may have thought one could be considered an art therapist after attending a weeklong seminar on the topic. They may not have been aware that art therapy training is an extensive process, equal to that of mental health counseling or social work where lengthy internship hours are also included.

The junior high school counselor was not very familiar with the field of art therapy although he once attended a one-day seminar on art therapy. He recognized the therapeutic qualities of art making from personal experience saying, "As an artist I can see the value of it and I would love some in-depth training on it." He had never worked with an art therapist before nor experienced an art therapy directive. He didn't know enough about art therapy to have an opinion about whether it would be good to use with the students he works with at the junior high, saying that until he had training and experience he would not know its value.

The elementary school counselor was somewhat familiar with art therapy. She had previously attended an art therapy workshop but felt a little turned off by the facilitator. She said, "The art therapist was like... 'you can never be an art therapist unless you do all of this fancy stuff' and that wasn't why we took the workshop; we wanted to know some things we could do." Her experience at the workshop with the territorial art therapist may have been related to the ongoing debate in the field of art therapy whether training programs should be merged with other fields such as mental health counseling or

social work or remain separate. The debate arises because most states do not have licensure programs for art therapists and most insurance companies will not cover or reimburse clients for seeking services from an art therapist.

The school counselor then gave her own definition of art therapy saying, “art therapy means the kids can express themselves using artistic form of any kind...to help them express the emotions they have inside.” She used art in various ways with her students, such as having them, “draw a picture of everyone in [their] house and what are they doing, then they have to tell me about it.” She explained what she might do for students who were grieving due to the loss of someone they cared about saying, “I ask them to draw a picture about it, or about the person, or make a card and express it the way they want to.” Other times she utilized art making with the students saying, “It helps them talk to me.” Overall, her understanding of art therapy was that, “it reveals things that you cannot get from them [verbally].”

She said having access to an art therapist for her work with the students would be a positive benefit. She thought that Navajo people as a culture, seem to be spatial in terms of understanding concepts and that incorporating an art therapist as a resource for students in need would be beneficial. In her experience, the kids responded “very well” to the different art therapy techniques she had been using. Her summarization was, “I would like more training in art therapy and it wouldn’t hurt to have...an art therapist up at the hospital [CCHCF] to work with kids who have had traumatic experiences.”

The medical social worker had heard of art therapy before, equating art therapy with music therapy. One of the psychiatrists with whom he previously worked had used music therapy and it had worked. He thought that art therapy was much like other forms

of therapy; you just use different tools for the same desired outcome. He said one of the current psychiatrists was using sand tray therapy and a few staff members may have used art therapy techniques, as he had been shown drawings made by clients and given interpretations of the drawings. The fact that several participants were using art making as part of the therapeutic process with clients, even making interpretations about drawings, may have affected participants' opinions on whether an art therapist would be more beneficial to the behavioral health clinic than having staff trained in art therapy. For some, the legitimacy of more formal training in art therapy may have been overlooked or thought of as unnecessary.

His views regarding the use of art therapy on the Navajo Reservation were, "Art therapy would work well with this population, especially with the kids...Kids are more open to doing things and they haven't been trained to think a certain way." He didn't know how the adults would respond and said, "It could go either way. As Navajo people, we are more right brain kind of folks...In general among Navajo adults it would work because of [the inclination] towards color for expressing ourselves." He said having an art therapist on staff,

Would work wonders. It would open up a new branch of stuff that we never thought about or had done. It would be awesome to have that, another arsenal in our pocket...We have psychiatrists who do [art therapy] but I think they are limited on what they can do.

The medical social worker/mental health specialist had some familiarity with art therapy. She learned about sand tray therapy from an art therapist while earning her degree. She said that sand tray therapy was similar to [Navajo] sand painting



remembering that she was told sand tray therapy originated from the use of sand paintings as a tool of traditional healing in ceremonies among the Navajo. She was interested in learning more about sand tray therapy and art therapy but equated both as being used with kids and said she wasn't good at working with kids. She said art therapy would be good with the Navajo clients because, "Some people come in and they say they don't know how to explain what they are feeling."

She thought it would be better to have staff training in art therapy rather than having an art therapist on staff, because the art therapist "might not be utilized." She said an art therapist would be treated with the same ambivalence as the other clinic staff, thus spending more resources on another position "would be wasteful." She commented on some of the problems the CCHCF Behavioral Health Department encounters regarding traditional Navajo mentality and incorporating western methods and ideas of mental health saying,

We have a high rate of no show...I don't think [the clients] have ever been explained how [therapy] works. I know a lot of them say 'I don't want to go to those crazy people,' [the clients] will say 'I'm not crazy' ...Even in counseling they say 'I just come here and talk, what's the use of doing that?' ...They want to see some results.

A medicine man or woman conducts a ceremony to negate ill effects or imbalance in a patient. The problem is addressed with a ceremony, or perhaps something concrete like herbs, or a song. The medicine man or woman does most of the work, the patient follows the directions of the healer, and an outcome occurs. The western approach of healing, specifically with behavioral health, is more interactive process oriented, client

driven, and takes time. The client or patient usually must continue to see the therapist over a period for change or a beneficial outcome. The effects on the client may be different as well from those coming from a medicine person using a traditional healing approach.

The medical social worker/mental health counselor had some experience with art therapy, having taken a class and read books on the topic. She felt art therapy crucial for certain patients, commenting that, “Children do it naturally. I used to work with kids. That’s the first thing you do. The smaller they are; you have to. There’s just no other way.”

She said providing art therapy as a service offered at CCHCF Behavioral Health, “would just fit perfectly for what we do here, or anywhere they have mental health counseling.” She commented on how the “left brain” approach to behavioral health that is adopted in most clinics and taught as part of a service providers training, doesn’t necessarily fit into the “right brain” thinking that is more natural for Native Americans. She said, “Art is right-brained, which is connected to the emotions. And that’s [how] people are trying to get healed, by getting in touch with their emotions.” She thought having an art therapist on staff would be beneficial over having staff trained in art therapy because an art therapist would, “get pretty fancy, whereas the rest of us, it’s just a tool that we use and maybe won’t go as far as an art therapist would.”

The social worker supervisor encountered play therapy, including sand tray, during her training at the University of New Mexico. She also worked with an art therapist during her practicum. She used sand tray therapy while working as a mental health specialist in Kayenta, AZ and said it was especially helpful for the very young

clients who had difficulty verbalizing important information. She was more successful in learning about their home situations using sand tray or play therapy rather than solely through verbal therapy. She said an art therapist would fit in well at the clinic if he or she was working with children but was uncertain about the use of art therapy with adults or the benefits of having an art therapist on staff for the adult population.

The substance abuse counselor/mental health specialist had no previous experience with art therapy. She thought using art therapy with the population she was working with would, “be very positive, if we can at least go full blast with it, because we need it.” Saying that, “Some children, they’re more expressive in drawing....They [children] would rather draw than verbalize.” She thought an art therapist would be beneficial for the behavioral health department saying,

[An art therapist] could fit anywhere, they could fit into the child family team or maybe, ‘hey this is one of our complicated cases, can we work with this individual through art therapy?’ I think it’s going to open up a lot of stuff...[Art therapy] is non-threatening.

She didn’t think it mattered whether staff was trained in art therapy or an art therapist was hired saying,

We could learn it [art therapy], or we could have a full time position [art therapist on staff]. It doesn’t matter, but I think that [art therapy] could really open up avenues [of treatment] for a lot of individuals, especially complicated cases.

The graduate student intern of mental health counseling hadn’t heard much about art therapy, but had attended a workshop for sand tray therapy. She liked to draw and found doodling comforting, even commenting, “You know, there’s some healing in

art...I've been curious about art therapy." She thought there was a need for an art therapist at CCHCF Behavioral Health, "because of the language barrier." She commented on how art therapy could be used as a tool for cross-cultural issues saying,

If [non-Natives practitioners] talk to...Navajo children, some of them will not respond...[Navajo children] don't respond well to the Anglo doctors. If you have an art therapist on staff, I think there would be a better understanding of the patient because the art therapist can interpret a whole lot from a picture, a painting...[Art therapy] has a lot of benefits.

The clinical psychologist, age 54 was not familiar with art therapy and had no previous experience working with an art therapist. He defined art therapy as,

Art is the therapy. When the person is doing the art that is the corrective experience. The art in and of itself is corrective for the individual with the disorder. From my perspective, the time that I have used crayons and paper with little kids, this has just been an opportunity for us to draw together, a place to connect.

He wasn't sure how well art therapy would be received by the adults. Regarding his thoughts on having an art therapist as part of staff he said,

I would love to have somebody to refer to for some of these non-verbal kids that I have seen, that need the opportunity just to be able to communicate with somebody else in a medium, in a way that is meaningful to them.

Though the clinical psychologist had no previous experience working with an art therapist or familiarity with the field of art therapy, he had formulated an opinion, created a definition, and was able to deduce potential benefits of using art therapy techniques at

the behavioral health clinic. The benefits of using a technique cross-culturally with foundations in the universality of art making were immediately apparent. Like many of his colleagues, art therapy was regarded as a solution when working with kids who did not respond to his techniques in verbal therapy.

The clinical psychologist, age 68 did not have any familiarity with art therapy and had not worked with an art therapist before. His thoughts regarding the use of art therapy at CCHCF Behavioral Health were, “[The Navajo patients] are very artistic and creatively oriented. I can see how art therapy would be useful to them, changing the way they think and expressing themselves in new ways.”

The CCHCF Behavioral Health Director and child psychiatrist was “somewhat” familiar with the field of art therapy. He understood art therapy beneficial in many ways saying it is used,

to develop a therapeutic relationship with a child or an adult...as a way to communicate something that may be difficult to express in words, especially by a child...as a way to express a certain emotion that is too painful to bring out... as a way to pursue treatment if there is a child who doesn't want to talk.

He previously had worked with someone where, “A big chunk of what they did was art therapy. And I've worked with folks who have used art therapy as part of their practice, but I have never worked with somebody who exclusively does art therapy.” He developed an increasing interest in art therapy, “because it is necessary.”

He had experienced art therapy when he was younger as well as during part of his psychiatric training. He thought that art therapy, “is extremely useful.” Adding, “I probably underuse it.” He explained how he uses art therapy saying,

Part of what I do with every kid age 11 and under as part of my assessment routine is, I ask them to draw a picture of where they stay at, which is an important concept...to a kid...I use [the picture] as a springboard for discussion. Sometimes I have them draw a little bubble and ask them ‘what is it they say to you?’ or I might just toss out interpretations...or I might use [the picture] as a way for the parent to connect to the child. I might use [the picture] to observe what that relationship is like.

He explained the way he personally uses art therapy to work with children who have experienced trauma saying,

Part of the treatment involves a narrative of the trauma that happened. Sometimes the kids will narrate that not through writing, but through art. The art work is used...to partially re-experience the event in a safe controlled environment.

Usually with someone who cares for them, their mother, father, or grandparent, who ask the child about the artwork or what they are feeling as they draw or after they finish the drawing...It is a useful way to get to the emotional content of an event.

He reported also having used art therapy with adults, saying he, “recently used art therapy with a 30-something year old who was experiencing anxiety.” Based upon research findings that a person can alter her anxieties if her focus is changed; he had the client draw four images in the process of retraining the patient’s anxiety. He explained the process saying,

If you look at two images, an anxious face and a relaxed face; if they flash in front of you an anxious person will automatically begin to look at the anxious face.

Their attention bias is already geared towards anxiety. In order to change the attention bias you would retrain them to focus on the calm face.

The CCHCF Behavioral Health Director may have thought the procedure he used with the client in an effort to retrain her anxiety to be art therapy because she made drawings, but in reality, the technique he was using had elements of art therapy, but was a cognitive behavioral application. Unless the art making itself was used for therapeutic purposes, such as an emotional release or for self-soothing, the art making was analyzed for emotional content or symbolism, or art work used as a safe talking point, then the director mislabeled the process he was using as art therapy. His misconception of art therapy may be a common one among professionals in the behavioral health field, which may lead to misunderstandings and minimization about the depth and range art therapy has therapeutically. Professionals in the behavioral/mental health field need more education and a greater understanding regarding alternative forms of therapy, such as art therapy.

In response to the question of whether or not it would be beneficial to have an art therapist on staff or have staff trained in art therapy the CCHCF Behavioral Health Director replied saying,

It is always a benefit to have someone who is more highly skilled and knows more about...or has done more of something if it is a useful technique... Yes, it would be helpful to have an art therapist [on staff]...It would be wonderful for more people to be trained in basic techniques of play therapy, sand tray, art therapy...[Art therapy] would be especially useful in working with younger children, but it could be used with adults too...Some of the traditional

practitioners [medicine men and women] are interested in what people draw, and they see things in the drawing. They value it as a way of expression too. That might be another way we could join with [the Native Medicine staff] in terms of assessment.

The psychiatrist also trained in psychotherapy, music therapy, and Core Shamanism, had experienced art therapy once as a patient. She was instructed to draw her experience of healing. As a therapist, she occasionally used art directives with children. She “stick[s] to things that I could see intuitively with my psychiatric training that would be meaningful...but that were artistically simple enough that I could do.” She also had encounters at a few different workshops and conferences where art therapy techniques were incorporated into the events, where she was encouraged to “use art as a way to express a psychological experience, whether it was specifically meant to be healing or not; that is a grey area.” Regarding how she felt her patients might respond to art therapy, she said,

Kids are kids and they love artwork, so that part is easy...I honestly don't know how the adults would respond. I think some would think it's cool, others would say ‘Who is this crazy biligaana [white person]?’ Most would be embarrassed, but perhaps not quite as much as a similar cross-section of white folks.

She then became inquisitive wondering, “I'm curious if Navajo patients would hesitate to draw something, or whatever kind of art, because it would reveal so much more than what they refuse to tell me, and would it make a difference if I were Navajo?” Regarding having an art therapist on staff she said,



I would prefer to see the various arts used...On the activity level it is all used a lot by non-professionals...I think we would be poor if we didn't have somebody who specialized in it, who could say, 'you know you've done it this way and this way, have you ever thought about these other six ways that are possible?'...Perhaps, more of a consulting thing is a possibility...I wouldn't want somebody that had a...twelve week course in being a psych tech and did a few little pictures... There is really something to be said about a professional who knows what they're doing.

The psychiatrist, age 59 was familiar with art therapy. He had several drawings hanging in his office made by some of his younger patients. He said that while working with an art therapist at Akron Children's Hospital, "We incorporated art therapy in our in-patient environment...Most places that I've been have not had that resource available."

He thought using more art therapy and/or having an art therapist on staff at CCHCF Behavioral Health, "would be a tremendous asset." He then described the approaches to therapy generally used saying,

Our typical approach is very linguistic in origin, very rational. The cognitive behavioral therapies are based on cognitions and thoughts...The Navajo people are...as a contrast with western society, they're very artistically oriented people...Tapping into [art therapy] as a resource and as an avenue for healing...could be a very good thing... It [art therapy] would be a wonderful addition.

He commented further saying,

I've been here for about a year but I personally think that we need to be much more multi-faceted than we are right now. Talk therapies have very limited accessibility here... We need to offer talk therapies, but there are a lot of people that are not interested in talk therapies... We need to build much stronger connections with... traditional healing methods... Art is another one that... from a traditional perspective has broad ramifications.

He said art therapy,

could include beadwork, weaving... Right now, I'm working on a project at the middle school that would include making bows and arrows in a traditional way... Making a bow and arrow might be more powerful than learning to say 'no' [regarding substance abuse refusal skills]... [art therapy] would be a very powerful addition and probably is an avenue we should explore.

Regarding whether he felt it would be better to have an art therapist on staff versus staff trained in art therapy he said,

An art therapist is a person who has that orientation and that training. The actual implementation may not be that different. An art therapist may actually help all the staff members amplify their use of art in their therapy, in their interventions, which... could be a good thing, but I don't see [whether to hire an art therapist on staff or train staff in art therapy] as a black and white line. I feel it could go either way.

### **Hypotheses**

Most importantly, the majority consensus of staff interview responses supported both hypotheses. Art therapy is an appealing and culturally appropriate form of therapy

for Native Americans. The participants recognized the importance of the arts and symbolism to the clients. Many of the participants were already incorporating art making or using art therapy directives successfully with their clients and more specifically out of necessity when verbal therapy or other options they had learned in their formal training were not working. All of the participants thought art therapy would be beneficial and work well with the clients, some specified that it would work well with the child clients but were uncertain about with the adults.

Art therapy has elements of both indigenous/traditional healing and western mental/behavioral health practices that may be a key element to foster better relations between the two fields, which often conflict. Problems existed between the Native Medicine and Behavioral Health Departments, and sometimes practitioners from each were at odds with one another regarding a diagnosis. Past clients of the behavioral health department had experienced anxiety and were torn between two seemingly opposing methods for treatment; those of western orientation and those from a traditional Native perspective. One of the participants suggested that art therapy may be a way for the two departments to find a common language and work together in conducting assessments, as the Native Medicine staff was already familiar with finding meaning out of client drawings.

Populations with traditional indigenous belief systems may better receive alternative approaches, such as art therapy, to standard verbal therapy. Many of the non-Native staff at times, was unsuccessful using verbal therapy with clients. In some instances, the problem arose due to language barriers, other times due to discomfort in

talking with a non-Native, and on occasion out of taboo over talking about a certain subject.

The existing tension among staff at CCHCF Behavioral Health Department that was inadvertently exposed through the research interviews and later addressed in the newly added cultural competency section of weekly staff meetings, is proof that cultural competency and contextual self-awareness are fundamental when working outside one's culture or ethnic group. There were distinct differences in the way Navajo and mixed European participants answered questions. They each had a unique understanding about the behavioral health field and how best to practice one's profession. Many staff members commented on personal problems they were experiencing with other staff members, or tension between staff and clients they had witnessed, with cultural issues being the source of the problems. Greater behavioral health staff cohesion, which leads to better client outcomes, can be helped with an ongoing dialogue addressing issues that arise when working cross-culturally. Everyone benefits from healthy cross-cultural engagement.

## **CHAPTER 4**

### **DISCUSSION**

#### **Introduction**

This thesis research was designed to explore whether art therapy would be considered beneficial to populations practicing indigenous or what some refer to as traditional belief systems and could be used as a bridge to connect western modes of psychotherapy with indigenous/traditional healing practices. Art therapy was viewed as a merger of two methods of healing, indigenous/traditional and western psychology. The contributions of this thesis to the field of art therapy is the insight of the participants, gleaned from years of experience with a Native American client base, on whether an art therapist, or creative arts/expressive arts therapist position should be considered by Indian Health Services as a welcomed and invaluable addition to the CCHCF Behavioral Health Department.

The behavioral health clinic staff, both Navajo and European-mix, provided services for Native American clients, many with indigenous/traditional beliefs in healing and spirituality, for several years. They knew the nuances of working with the population, both as being Native Americans from the same tribe or as someone coming in from a different ethnic group and culture. Their personal experiences provided contextual awareness to their insight and opinions about art therapy as well as revelations on the importance of cultural competence when working cross-culturally both as service providers and as fellow behavioral health department staff. The realization of the hypotheses would speak for the desirability of creating art therapy positions throughout all IHS facilities offering behavioral/mental health services and stress the importance of

cross-cultural engagement, cultural awareness, and sensitivity when working cross-culturally, not just with clients, but with colleagues as well.

**Context.** Often, when embarking on a new journey, offering services in an unfamiliar place to a group of people whose culture, ethnicity, and world-view may be quite different from our own, we do not think about whom we are in context to the community we serve. Assumptions are made, that we have something to offer and the community would benefit from our services. Before we can begin helping patients, we as staff need to look at ourselves. We must consider whether the services we offer via our theoretical training really ‘fit in’ with the needs and world-view of the people for whom we provide services. We must evaluate how we as staff work together and feel mutual respect, addressing what tensions may exist and why and whether they are also present with patients. If practitioners fail to step outside of their comfort zones and develop greater contextual self-awareness they will never become a welcomed and fully integrated addition to their new community.

I deduced from quantitative evidence, the relevance and importance of environment and context to survival in a class called *Psychopharmacology of Drug Abuse and Pharmacotherapies* while attending a Substance Abuse LADAC certification program with the University of New Mexico Continuing Education in 2011-2012. During the class we read about and discussed the implications of the outcome from an interesting study, ‘the study of learned tolerance,’ regarding heroin use in rats. ‘The study of learned tolerance’ was provided as an example of conditioning opponent processes. In the study, rats received IV injections of heroin for 30 days. The context or research variable was the environment in which the heroin was administered, whether it was the same environment

from previous heroin administrations or a novel environment. Thirty-two percent of the rats in the study died when administered a larger dose of heroin than previously administered, while in the same environment as before. Sixty-four percent of the rats died when administered a larger dose of heroin than previously administered, in a new or novel environment.

These research findings with rats, if replicated with humans, would have major implications regarding the effects of context and environment on humanity; subjective experience is no longer in the realm of ‘soft science.’ Medical Anthropologists have been conducting research for decades on the basic premise that environment and the context of our surroundings have a major impact on our survival and welfare (B. Obermeyer, personal communication, 2013). Contextual awareness is fundamental in understanding the needs of people to whom we provide services.

A discussion came up in the fall of 2011 at a Native American Church (NAC) meeting I attended. NAC is a spiritual and religious practice that uses peyote and songs as the main source of medicine and healing. The conversation started when one of the attendees asked me what my interest was in NAC. The roadman (the person who facilitates the proceedings in an NAC meeting) then told a story of a meeting he attended with two non-Navajo/non-Native researchers from Harvard University. He said the two researchers were busy taking notes much of the night. At one point, the peyote they had ingested started adversely affecting them and they left the teepee to vomit. Upon return to the meeting, they were asked if they were going to record their biological reactions to the peyote. Their response was “no” (NAC roadman, personal communication, October 28, 2011).

I understood the purpose of the roadman's sharing of this story to serve as a lesson and reflection. There is often an attempt to make research purely objective. There cannot be a separation of who one is, what one observes, or the context of how one participates, especially in the realms of culture, identity, human behavior, and psychology. Who we are effects how we perceive and communicate about the world around us. The personal experiences of the Harvard researchers during the peyote meeting were as relevant and important to their research as the "objective" note taking and observations they were making of the others during the meeting.

An elemental part of Navajo tradition is the introduction of your clans (part of Ke'), acknowledging and giving credence to where you came from and who you are. These introductions provide roots to draw from when meeting new people, or speaking in front of a crowd, giving context and deeper meaning to one's words, background, origins, thoughts, and general perspective in life. Much of this information I gleaned while conducting my thesis research on the Navajo Reservation through daily interaction with others; I also formally learned about Navajo clan systems while enrolled at Dine College, Shiprock Branch in the Foundation of Navajo Culture course taught by Professor Martha Austin-Garrison (personal communication, Spring 2011).

I would like to introduce myself, the researcher, the person behind the hypotheses, speculations, and musings. My name is J. Olivia Drumm. I am the youngest of four girls with whom I grew up, and the sister of five stepbrothers who became part of my family after both of my biological parents remarried. I was raised in a rural town of 11,000+ people about 1 hour due west of St. Louis, Missouri. I grew up learning Christian religious beliefs (my father served as a Lutheran minister until I was three months old)



and was introduced to Jewish belief systems when my mother remarried my stepfather, who is Jewish. I view myself as spiritual, not focusing on or upholding the beliefs of a particular religion; rather, I have interest in the power of belief and source of what creates religion. I am an American artist and philosopher of life, of mixed European ancestry, and graduate art therapy student at Emporia State University (ESU) in Emporia, Kansas, USA.

While attending a semester of art school at the Pennsylvania Academy of Fine Arts in 1999, I was roommates with my good friend, R. Danayi Nyadenga. Danayi is Shona, originally from Zimbabwe, and was trained in traditional African healing by his grandfather. Our meeting resulted in my informal and personal introduction into indigenous/traditional healing practices. He is an artist in residence in South Africa. Danayi and I co-presented an Experiential Workshop, 'Using the Visual Arts as a Bridge to Healing', at the 2<sup>nd</sup> Annual Conference on Integrating Traditional Healing Practices into Counselling Psychology, Psychotherapy, and Psychiatry at the University of KwaZulu Natal in Durban, South Africa in July of 2010.

In the summer of 2008, just before I started taking classes at ESU, I attended a Squaw Dance, in support of a long time friend. A Squaw Dance is more formally recognized as a Navajo Ndaa' or Enemy Way Chant (Anaa'ji'). The Enemy Way Chant is frequently used in healing or purification ceremonies for Veterans returning from war, often who exhibit symptoms of Post Traumatic Stress Disorder (PTSD). It can also be used with Navajos who have married, are seeing, or have children with someone who is not Navajo, to negate the imbalance that is thought to occur from the interaction. The ceremony took place in both New Mexico and Arizona on the Navajo Reservation.

During my internship experience with the Navajo Regional Behavioral Health Center (NRBHC) that preceded my thesis research in Chinle, I became aware of biases and naiveté I had not yet recognized. Interning with NRBHC helped me create more accurate and appropriate interview questions and fostered a better understanding of the context in which interviewees were speaking. While interning I came to the realization that I could not approach art therapy in the same context I did at previous internship sites in Kansas. This awareness came when I unknowingly had my patients participate in an art directive that was taboo for Navajos upholding traditional beliefs. One of the participants had a problem with the directive, but did not feel comfortable telling me, so he went ahead and participated. Later, during the week, one of the medicine men on staff confronted me regarding this incident. The medicine man had to conduct a ceremony to negate the effects of the art therapy directive on this particular client.

This learning experience instilled a greater thoughtfulness and effort on my part to consider contextual and self-awareness. I began consulting with the traditional practitioners and medicine men on staff so that I could offer art therapy services that were respectful of the culture. Cultural nuances and taboos were made aware and integrated into the art therapy service structure. The experience also supported my hypothesis of the link between art therapy and traditional healing. There were several instances during the internship in which my art therapy directives for the clients, or client art making activated elements of the ‘spirit realm’ in which the traditional practitioners necessarily became involved.

I introduce these events and myself in an effort to create context regarding how my research interest began and the benefits of community immersion prior to conducting

the thesis interviews. I wanted to provide insight into the directions I took and perspective cultivated. The roots of this research thus exposed, just as the insight of the participants. Who the researcher is, in context, is also a contributor to the outcomes of her own research.

### **Limitations**

My non-Native American, non-Navajo ethnic background may have impacted participants' responses and comfort levels in working with me. I do not speak or understand Diné. Participants who may have preferred to speak Diné or their native language may have been affected negatively by having interviews conducted only in English. Participants may also have found it strange to be working with a student researcher who came from out-of-state. They may have been wary of my motives in conducting the research and questioned how my work might benefit their clients.

Providing the single experience of the scribble technique may have been inadequate for an introduction to and subsequent assessment of art therapy. Participant responses may have been affected by my dual role as interviewer and provider of an art therapy experience. Participants may have felt inhibited in giving true responses or opinions about art therapy knowing that I was an art therapy student previously interning with DBHS, especially if participants were aware of my mentor relationship with Ray Daw who was at that time the Navajo Nation Director of Department of Behavioral Health Services.

Having the art therapy questions at the end of the interviews may have affected the participants' responses as well. Participants may have felt the art therapy questions were of less importance, or may have become tired from the interview process and not

put as much effort into formulating opinions and thoughts regarding art therapy. The limited number of art therapy questions compared to the time spent on personal background and professional profiles may also have been a source of marginalization. The interview questions may have been biased, especially the way I worded some of the questions about art therapy and asked about cultural relativity; this may have provided evidence of my background as a graduate student who had studied anthropology.

There are definitely changes I could make to improve this study, such as choosing more neutral words to portray concepts. For example, instead of using the terms indigenous or traditional, I might use more basic wording inferring the meaning and concepts the words convey. Nonetheless, the interview questions were sufficient as a starting point in eliciting unplanned responses and promoting discussion among staff.

It may have been more advantageous to first intern as an art therapy student at the Chinle site before doing the interviews, to give staff a better idea of art therapy, and how art therapy affects the clients they serve. Most of the art therapy questions were based on conjecture rather than long-term experience using art therapy with the clientele of the behavioral health staff. A larger number of the staff may have participated if I had first interned at the site as well, giving them an opportunity to learn more about me. In addition, they would have had greater exposure to art therapy. The short duration of time allotted for participation in interviews may also have affected the number of participants.

Acquiring permission to conduct research from the Navajo Nation IRB was time consuming and involved a major commitment to the process as well as patience.

Obtaining the required permission from the Navajo Nation IRB to conduct research on the Navajo Reservation was also very different than the IRB process at Emporia State

University. The Navajo Nation IRB process was a new experience and involved many mistakes and additional meetings with the IRB and other necessary entities (i.e. local Chapters and boards) to get approval to conduct the study.

### **Implications for future research or practice**

**Cultural tensions.** Historical trauma created wariness in many Native Americans when evaluating the sincerity of non-Natives who provide services. Many non-Natives only work briefly at an IHS facility as part of their student loan forgiveness program, out of curiosity, due to lack of employment in other areas of the country or because they simply perceive a need to assist (short term) the ‘underserved’ populations of the United States. Often, non-Natives come to the reservation with preconceived notions and the desire to “save the Indians.” The provider-client relationship may therefore exist with undertones of patronization.

Non-Native service providers may be unaware of their own biases, stereotypes, and perhaps even underlying racism they may bring to the reservation. They may not have a thorough understanding of the group with which they are working and how as ‘outsiders’ they fit into the dynamics of the culture. Non-Native providers may not know how to become part of the new community, or how to be respectful. They may feel reverse racism and if of European descent, a ‘blame and/or fear the white man’ attitude, which developed out of necessity to survive generations of colonial oppression that persisted due to unresolved bitterness. Hardships may discourage some to work only briefly on the reservation; thus creating a constant rotation of new ‘non-Natives’ into the community who never become fully invested. A cycle of distrust and ignorance is then in constant repetition and seemingly justified.

A continually enforced gap in understanding and communal interaction exists between Native and non-Natives service providers and clientele. One of the participants had a lot to say about “outsiders” coming into the Navajo Reservation. Her thoughts were much like those of many others I encountered during my research in New Mexico and Arizona. She commented on my study, saying that non-Natives would come to the Navajo Reservation “wanting to write something about the Navajos...We are always being labeled.”

She summarized why contextual awareness and cultural competency is important when working outside your ethnic group or culture by using her previous experience working as a school counselor on the reservation to provide an example of the attitude many non-Natives have when coming to the Reservation for work, saying,

We get students from all over the place to do their student teaching...They come here with the impression that ‘I’m going to save these Indians’...Mainstream society [has] the impression that [Native Americans] are the underachievers and will always rely on the government...We don’t. [Non-Natives often think] that we are just a bunch of people that live on welfare...That puts up a shield.

These teachers, they don’t understand some of the household situations of these students...The student may be doing poorly in school because of maybe no running water in the home and the student did not take a shower, did not want to come to school because he did not have clean clothes. The [non-Native] teacher may not understand that and automatically assume that kid is lazy, doesn’t want to learn, doesn’t want to come to school...I’ve heard it so many times because I am in education...you have to teach the [non-Native] teachers...where these students

are coming from. Some will not understand. 'That's not my problem.' Well sorry. You may say that's not your problem, but you are in a different culture right now. You're in a different world right now. Where you're coming from, let's leave that behind...You have to make [non-Natives] understand that. Some, they can't; I guess, they can't hack it and just leave.

It truly is necessary to develop greater self- awareness and cultural sensitivity when working outside your ethnic group or cultural norm. The goal for any department is staff cohesion. Everyone, individually and as a group, must evaluate what and why tensions may exist and create a dialogue with one another in a safe space, fostering better relations. Healthy cross-cultural engagement with everyone involved is a must.

**Community immersion.** If possible and time permits, behavioral health professionals who will be offering services to clients from another culture or ethnic group would benefit immensely from community immersion prior to initiating employment. They should begin familiarizing themselves with the foreign culture immediately upon acceptance of a position in a land unfamiliar to their own and/or with clients from a very different cultural or ethnic background. People from the foreign culture, who are knowledgeable about the culture specific beliefs and practices, should be sought out as advisors. Frank discussions on what is "normal" are crucial as well as developing a cultural understanding of mental health, mental illness, and well-being. Familiarization with traditional healing approaches and taboos within the culture will help in building trust with clients as well as aid in the creation of new therapeutic techniques designed within the framework of a particular culture. Practicing cultural relativity specific to the group one works is necessary for productive therapeutic service provision.

## **Conclusion**

Why would art therapy be more comforting than western modes of verbal therapy for populations wary of western psychology, when the foundations of art therapy are Eurocentric? One of the answers lies within choice of using art making as a major part of the therapy process. Art making does not require verbal language. Anyone can express him or herself visually and convey an emotion cross-culturally to a person who does not speak or understand the same form of verbal communication. The use of symbols is universal. Visual symbol systems and cues are often absorbed in the mind and learned more quickly than verbal or written language.

Art therapy as a field is fluid, malleable, and adaptable theoretically. The rapidity with which each major theory in western psychology was absorbed into the art therapy curriculum and explored, assimilated, or discarded is evidence. Many art therapists use integrative and intuitive theoretical models with their clients, using techniques learned from a variety of psychological theoretical orientations.

As you may deduce, I am biased towards the use of art therapy. I entered the Navajo Community thinking art therapy would be beneficial. I felt my efforts would be of help, would be appreciated culturally, and should be offered as part of the behavioral/mental health services provided on the reservation. I brought a certain mindset and goal to finish my internship hours at the Navajo Regional Behavioral Health Center in Shiprock, New Mexico and conduct research at the Chinle Comprehensive Health Care Facility in Chinle, Arizona.

I am not unlike most students in psychology, or professionals entering a new position. Assumptions are made that we have something to offer and the community



should welcome, appreciate, or benefit from our help. I had excitement about my work and felt it would be beneficial. Enthusiasm is important for survival, but if one is not careful, enthusiasm can make us blind. We can be so caught up in what we hope for in our work, that we are not fully aware of the subtleties some counter-productive, which exist.

Several participants in the study hinted at or directly addressed the tension that existed between the Native Medicine staff and CCHCF Behavioral Health Department. They expressed that the two departments were sometimes at odds with one another regarding how Native Medicine Department services should be integrated with services offered at the Behavioral Health Department. Clients likely could also feel the tension between the two departments. Some clients felt torn between which type of treatment to use; they believed they had to make a choice between traditional medicine and western modes of therapy, as they realized the two approaches differed and at times conflicted.

This dichotomy of choosing between indigenous/traditional and western approaches of healing may be viewed as part of the conflict many bicultural individuals experience while living in “two worlds.” When working with such clients, providers must consider ways to honor traditional beliefs yet offer services through westernized concepts of treatment. Art therapy can be one of the methods to help integrate the two opposing methodologies. A common language can be found in art, where bi-cultural clients do not have to feel torn between differing approaches of therapy or healing and previous oppositional service providers can work together. Even with the common language of art, a culture specific set of art therapy directives would need to be created for each new group one was working. Art therapy should be considered as an essential component to

all behavioral/ mental health departments offering services to populations with indigenous/traditional belief systems and to ethnic groups and cultures varying from those of the service providers.

Alternatives to western constructs in psychology, such as art therapy, can be the catalysts for an entirely new mode of healing and way of offering therapeutic services. Rather than having the same perspectives acknowledged or spoken in diverse languages, an approach that seems to be the way diversity is portrayed in American Psychology, an altogether different methodology for understanding, identifying, and discussing human behavior, psychology, wellness, and diagnoses will be created.

The adaptability of art therapy and the field's relative youth in the behavioral/mental health community gives rise for the creation of a unique discipline. The field of art therapy is ripe for the merger and incorporation of diverse cultural and ethnic perspectives within the healing arts. Art therapy has the potential to be a true multi-cultural form of behavioural/mental health treatment and healing process, with methods dating back to antiquity.

## REFERENCES

- Aberle, D. F. (1966). *The peyote religion among the Navaho*. Chicago: Aldine.
- Achterberg, J. (1985). *Imagery in healing: Shamanism and modern medicine*. Boston: Shambhala.
- Acrey, B.P. (1979). *Navajo history: The land and the people*. Shiprock: Department of Curriculum Materials Development Central Consolidated School District No. 22.
- Acrey, B.P. (1996). *Navajo history to 1846: The land and the people*. Shiprock: Department of Curriculum Materials Development Central Consolidated School District No. 22.
- American Psychiatric Association (APA<sub>1</sub>). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association (APA<sub>1</sub>). (2012). *APA history*. Retrieved from <http://www.psych.org/MainMenu/EducationCareerDevelopment/Library/APAHistory.aspx>
- American Psychological Association (APA<sub>2</sub>). (2012). *APA history*. Retrieved from <http://www.apa.org/about/archives/apa-history.aspx>
- Aponte, J. F. & Morrow, C. A. (1995). Community approaches with ethnic groups. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp.128-144). Needham Heights, MA: Simon and Schuster.
- Appleton, V. E. & Dykeman, C. (1996). Using art in group counseling with Native American youth. *The Journal for Specialists in Group Work*, 21(4), 224-231. doi:10.1080/01933929608412254

- Arrington, D. (2005). Global art therapy training: Now and before. *Arts in Psychotherapy, 32*(3), 193-203. doi:10.1016/j.aip.2005.03.006
- Brave Heart, M. Y. H., & DeBruyn, L. M., (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2), 60-82. doi: 10.5820/aian.0802.1998.60
- Bell, J. (2008). *Doing your research project: A guide for first-time researchers in education, health and social science* (4<sup>th</sup> ed.). Berkshire, United Kingdom: Cromwell Press.
- Brooke, S. L. (2004). *Tools of the trade: A therapist's guide to art therapy assessments* (2<sup>nd</sup> ed.). Springfield, IL: Charles C. Thomas.
- Carolan, R. (2001). Models and paradigms of art therapy research. *Art Therapy: Journal of American Art Therapy Association, 18*(4), 190-205.  
doi:10.1080/07421656.2001.10129537
- Coleman, V. D., & Farris-Dufrene, P. M. (1994a). Art and healing for Native American Indians. *Journal of Multicultural Counseling & Development, 22*(3), 145-152.  
doi:10.1002/j.2161-1912.1994.tb00460.x
- Coleman, V. D., & Farris-Dufrene, P. M. (1994b). Art therapy with Native American clients: Ethical and professional issues. *Art therapy: Journal of the American Art Therapy Association, 11*(3) 191-193.
- Coleman, V. D. & Farris-Dufrene, P. M. (1996). *Art therapy and psychotherapy: Blending two therapeutic approaches*. Washington, DC: Taylor & Francis.
- Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Allyn & Bacon.

- Davies, W. M. (1998). *Navajo health care in the twentieth century*. USA: Arizona State University, UMI Company.
- Deloria, V. Jr. (1969). *Custer died for your sins: An Indian manifesto*. New York: Macmillan.
- Drumm, J. O. (2009). *Art therapy as a bridge between traditional healing methods and western psychology: A Native American perspective*. Unpublished raw data.
- Dufrene, P. (1991). Utilizing the arts for healing from a Native American perspective: Implications for creative arts therapies. *Canadian Journal of Native Studies*, 10(1), 121-131.
- Farris-Dufrene, P. & Garrett, M. (1998). Art therapy and Native Americans: Blending culture, creativity and healing. In Hiscox, A. R. & Calisch, A. C. (Eds), *Tapestry of cultural issues in art therapy* (pp. 241-248). Philadelphia: Jessica Kingsley.
- Ferrara, N. (1998). Art therapy with a Cree Indian boy: Communication across cultures. In Hiscox, A. R. & Calisch, A. C. (Eds), *Tapestry of cultural issues in art therapy* (pp. 49-84). Philadelphia: Jessica Kingsley.
- Garrett, M. W. & Pichette, E.F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development*, 78, 3-13. doi:10.1002/j.1556-6676.2000.tb02554.x
- Garrett, M. T. & Portman, A. A. (2006). Native American healing traditions. *International Journal of Disability, Development and Education*, 53(4), 453-469. doi:10.1080/10349120601008647
- Gage, B., & Gage, G. (2007). *American Outrage*. U.S.A: First Run Films Human Rights Watch. Retrieved from <http://www.bullfrogfilms.com/catalog/amout.html>

- Grimberg, S., Makepeace, A., Zwonitzer, M. & Erye, C. (2009). After the Mayflower. American Experience, *We Shall Remain*. Washington, DC: Public Broadcasting Service. Retrieved from <http://www.pbs.org/wgbh/amex/weshallremain/>
- Henderson, D. A., & Gladding, S. (1998). The creative arts in counseling: A multicultural perspective. *The Arts in Psychotherapy*, 25, 183-187. doi: 10.1016/S0197-4556(98)00011-2
- Koss-Chiono, J. D. (1995). Traditional and folk approaches among ethnic minorities. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp.145-163). Needham Heights, MA: Simon and Schuster.
- LaFromboise, T. D. (1988). American Indian Mental Health Policy. *American Psychologist*, 43(5), 388-397. doi: 10.1037/0003-066X.43.5.388
- Lawrence, J. (2000). The Indian Health Service and the sterilization of Native American women. *American Indian Quarterly*, 24(3), 400-419. doi:10.1353/aiq.2000.0008
- Levy, J. E. (1998). *In the beginning: The Navajo genesis*. Berkeley, Los Angeles/London: University of California Press.
- Malchiodi, C. A. (1998). *The art therapy sourcebook: Art making for personal growth, insight and transformation*. New York: McGraw-Hill.
- Marks, L. (2006). Global health crisis: Can indigenous healing practices offer a valuable resource? *International Journal of Disability, Development and Education*, 53(4), 471-478. doi: 10.1080/10349120601008688
- McNiff, S. (1992). *Art as medicine: Creating a therapy of the imagination*. Boston: Shambhala.

- Moodly, R. & West, W. (Eds.). (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.
- Moody, J. (1995). Art therapy: Bridging barriers with Native American clients. *Art*
- Moon, C. (2010). *What do materials mean? Material theory in art therapy*. Paper presented at the Emporia State University Art therapy Discovery Day 2010.
- O'Meara, S. & West, D. A. (Eds.). (1996). *From our eyes: Learning from indigenous peoples*. Toronto: Garamond.
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (Eds.) (2008). *Counseling across cultures* (6th ed.). Thousand Oaks, CA: Sage.
- Riley, A. (Ed.). (1993). *Growing Up Native American*. New York: Avon Books.
- Rubin, J. A. (1999). *Art therapy: An introduction*. Lillington, NC: Edward Brothers.
- Rubin, J. A. (Ed.). (2001). *Approaches to art therapy: Theory and technique* (2nd ed.). New York: Brunner-Routledge.
- Rubin, J. A. (2005). *Artful therapy*. Hoboken, New Jersey: John Wiley and Sons.
- Running Wolf, P., Soler, R., Manteuffel, B., Sondheimer, D., Santiago, R. L., & Erickson, J., S. (2002). *Cultural Competence Approaches to Evaluation in Tribal Communities*. Symposium on Research and Evaluation Methodology: Lifespan Issues Related American Indians/Alaska Natives with Disabilities.
- Sandner, D. (1991). *Navaho symbols of healing: A Jungian exploration of ritual, image, & medicine*. Vermont: Healing Arts Press.
- Takini Historical Trauma. (2012). *Home Webpage*. Retrieved from <http://www.historicaltrauma.com/>

- The Navajo Nation. (2012). *History*. Retrieved February 9, 2012 from  
<http://www.navajo.org/history.htm>
- Thornton, R. (1987). *American Indian holocaust and survival: A population history since 1492*. Norman, OK: University of Oklahoma Press, 1987.
- Thornton, R. (Ed.). (1998). *Studying Native America: Problems and prospects*. Madison, WI: The University of Wisconsin.
- Toensing, G. (2012, February 8). The Dawes Act started the U.S. land-grab of Native territory. *Indian Country Today Media Network*. Retrieved February 9, 2012, from <http://indiancountrytodaymedianetwork.com/2012/02/08/96582-96582>
- Turner, S. (2002). Training counselors to work with Native American clients. Paper presented at the 109<sup>th</sup> Annual Conference of the American Psychological Association, San Francisco, CA.
- U. S. Census Bureau. (2010). *The American Indian and Alaska Native populations: 2010 Census Briefs*. Retrieved February 9, 2012 from  
<http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>
- U. S. Department of Health and Human Services, Indian Health Services (IHS). (2009). *IHS fact sheet*. Retrieved from <http://info.ihs.gov/QuickLook09.asp>
- U. S. Department of the Interior, Bureau of Indian Affairs (BIA). (2009). *Services overview*. Retrieved from <http://www.doi.gov/bia/>
- U.S. Department of the Interior, National Park Service (NPS). (2012). *Canyon de Chelly*. Retrieved March 21, 2012 from <http://www.nps.gov/cach/index.htm>
- U.S. Department of Justice, Bureau of Justice Statistics (BJS). (1999). *American Indians and Crime*. Retrieved from <http://www.ojp.usdoj.gov/bjs/pub/pdf/aic.pdf>



Wadeson, H. (Ed.) (1992). *A guide to conducting art therapy research*. Mundelein, IL: American Art Therapy Association.

Watters, E. (2010). *The globalization of the American psyche: Crazy like us*. New York: Free Press.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R. & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(6), 119-130.  
doi:10.1023/B:AJCP.0000027000.77357.31

Yeh, C., Hunter, C., Madan-Bahel, A., Chiang, L., & Arora, A. (2004). Indigenous and interdependent perspectives of healing: Implications for counseling and research. *Journal of Counseling & Development*, 82(4), 410-419. doi:10.1002/j.1556-6678.2004.tb00328.x

## Appendix A

### Personal Background Interview Questions

## **Personal Background**

1. What is your definition of culture?
2. What is your cultural background? What is your ethnic background? What languages do you speak? What languages did you grow up speaking?
3. Where were you born/raised? What type of environment were you raised? (city, country, town, reservation) Describe your home environment.
4. Where have you lived? How much and where have you travelled?
5. Were you raised with religious beliefs? If yes, what are they? Do you currently have religious beliefs?
6. What is your definition of a traditional person? A non-traditional person? What is your definition of an indigenous person? What is your definition of a non-indigenous person? What is your definition of a mainstream/modern/assimilated person? What is your definition of “Western culture”? Where you do fit on the spectrum, how do you identify yourself?

## Appendix B

### Professional Interview Questions

### **Professional Interview Questions**

1. What sparked your interest in the field of mental health/healing profession? What brought you to this place you are working? What is your interest in working with the population you are serving?
2. What was your training like for your position? Do you feel you were adequately prepared to work with the population you are now serving?
3. What is your understanding of your role in the field of mental health? How do the skills you have help the patients?
4. How does your training differ from the other mental health professionals in the treatment team? What is your understanding of the roles of the other members of the treatment team? How do the varying skills of each member of the treatment team “fit” together ?
5. What is your definition of mental health? Mental illness? What do you believe is/are the origin(s) of mental illness?
6. What is your goal for the patients you work with? What is your understanding of healing, curing, or treating a patient?
7. Are you familiar with the field of art therapy? Have you worked with an art therapist? Have you experienced an art therapy directive?
8. What are your thoughts on using art therapy with the population you serve? How would patients respond?
9. How would/does an art therapist “fit” in to the current treatment team? What would be the benefit of having an art therapist on staff rather than staff who use art therapy?

Appendix C  
Informed Consent Document

## INFORMED CONSENT DOCUMENT

I, J. Olivia Drumm, am a graduate art therapy student at Emporia State University (ESU) in Emporia, Kansas. I am conducting a research study to better understand the specific roles of each member of the Behavioral Health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans. The study will help the behavioral health treatment staff better understand their roles in a treatment team, how their specific training can better help the healing process in interaction with the other behavioral health practitioners, enhancing the effectiveness of the patients' recovery process and behavioral health maintenance overall. This research will form the basis of my master thesis; the final requirement toward earning a Master's of Science in Art Therapy.

The Department of Psychology at Emporia State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided for you to decide whether you wish to participate in the present study. Be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach. Likewise, if you choose not to participate, you will not be subjected to reprimand or any other form of reproach.

I will conduct informal interviews. I will take notes and record the interview(s) with a tape recorder or other type of recording device available. The interview(s) may take from fifteen minutes to three hours. I will take photographs of participant artwork, research tools, and the CCHCF Behavioral Health treatment facility. I will use pseudonyms to maintain confidentiality. Copies of recorded information will be given to the Navajo Nation Institutional Review Board and the Navajo Nation Department of Behavioral Health. My personal copies will eventually be destroyed (tapes erased, papers burned). All recorded information for the research project will be kept in a locked compartment of my car and in a secure filing box in my current place of residence in Shiprock, NM.

If time permits, you have the option to create an art piece and artist statement, poem, or song over your reflection of self as healer/therapist/behavioral health facilitator. The artwork and artist statements/poems/songs created as reflection of self as healer/therapist/behavioral health facilitator will be exhibited. Participants have the option to have their identities displayed with their art pieces and artist statements or to have the identities remain confidential. I will discuss and confirm identity confidentiality with each participant before exhibiting her or his artwork.

I will present the results of the study as my Master's thesis at Emporia State University. I will use participants' artwork, artist statements, interview responses, and photos for the art exhibit and educational purposes. Identifying data (participant name, photo, etc.) will be kept confidential upon request. The artwork will be returned after an art exhibit on the Navajo Reservation and at Emporia State University.

**If you have further questions, you may contact the Navajo Nation IRB:**

Beverly Becenti-Pigman  
Board Chair, Navajo IRB Office  
Navajo Division of Health  
PO Box 1390  
Window Rock, AZ 86515

Phone: (928) 871-6650  
Fax: (928) 871-6259

**You may contact me at:**

J. Olivia Drumm  
PO Box 834  
Shiprock, NM 87420

E-mail: [jdrumm@emporia.edu](mailto:jdrumm@emporia.edu)  
Phone: 314-223-1462.

**You may also contact the head of the art therapy department at ESU:**

Dr. Gaelynn P. Wolf Bordonaro  
Campus Box 4031  
Emporia State University  
1200 Commercial  
Emporia, KS 66801-5087

Email: [gwolf@emporia.edu](mailto:gwolf@emporia.edu)  
Phone: (620) 341-5809

*"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."*

\_\_\_\_\_

Subject

\_\_\_\_\_

Date

\_\_\_\_\_

Guardian Consent

\_\_\_\_\_

Date



## Appendix D

### The Scribble Drawing Assessment

## **The Scribble Drawing Assessment**

The scribble technique is a projective assessment technique developed independently in the 1940s by the American art teacher and artist Florence Cane and British psychoanalyst and pediatrician Donald W. Winnicott. Winnicott called it the squiggle game and used it with his child patients to get to know what was on the mind of the child as quickly as possible (Rubin, 2005). Cane referred to it as the scribble drawing, or scribble technique, and used it to facilitate spontaneous expression and help release imagery dormant in the participants' unconscious (Rubin, 2005). Cane's experience as a dancer influenced her inclusion of movement and breathing exercises as part of the warm-up to the scribble drawing technique. The scribble technique has been adopted by many art therapists to establish rapport with participants through a decrease in anxiety and resistance (Rubin, 2005).

Participants are given a blank piece of paper (roughly 8 ½" x 11" or larger) and colored pencils, crayons, markers, or pastels (many types of media can be used). They are then asked to swing their arms around freely, while moving their body and scribbling in the air. After the participants have loosened their bodies, they are asked to close their eyes and scribble on the piece of paper in front of them. Sometimes, the same directives above are given but participants are allowed to keep their eyes open; in this case they are often asked to use their non-dominant hand, or the body movement portion is skipped (Rubin, 2005).

Once the participants are finished with the scribbles, they are asked to look at the scribbles from different angles. They are asked to find an image or images that can be seen in the scribbles. They are then asked to develop these formal images into a more

concrete picture by omitting scribble lines in different places, covering up spaces, and adding new lines, shapes, and colors if necessary, so others are able to clearly see the same image(s). The participants are then invited to talk about what significance and meaning the image has for them (Rubin, 2005).

Appendix E

Navajo Nation IRB Proposal

NAVAJO DIVISION OF HEALTH  
Navajo Nation Human Research Program  
**IRB Research Protocol Application**  
(THIS COVER SHEET MUST BE SUBMITTED WITH YOUR PROTOCOL)

Date: 11/29/2010

Protocol Title: Utilizing art therapy for healing as part of an integrative mental health treatment team Interviews from the Navajo Reservation

Name of Principal Investigator: J. Olivia Drumm

Title/ Affiliation of the PI: Graduate Student of Art Therapy, Emporia State University

Name(s) of the Co-Principal Investigators: \_\_\_\_\_

Address: PO Box 834

City Shiprock State: NM Zip Code: 87420

Phone: (314) 223-1462

Fax: \_\_\_\_\_

E-mail: onadrumm@yahoo.com

**Official Navajo IRB Use ONLY**

Application Received: ___/___/___	Progress Report Received:
NNHRRB Approval Date: ___/___/___	1 <sup>st</sup> qtr: ___/___/___
Proposal ID#: NNR-___ - ___	2 <sup>nd</sup> qtr: ___/___/___
IHS IRB Action Letter: ___/___/___	3 <sup>rd</sup> qtr: ___/___/___
Continuation Request: ___/___/___	4 <sup>th</sup> qtr: ___/___/___
Research Final Report: ___/___/___	Annual Report: ___/___/___

NNHRRB-01  
10/28/02



**J. Olivia Drumm, Emporia State University student # 10334590**

**Abstract: Utilizing art therapy for healing as part of an integrative behavioral health treatment team: Interviews from the Navajo Reservation**

The purpose of this proposed qualitative study is to better understand the specific roles of each member of the behavioral health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each behavioral health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans. The hypothesis is that art therapy is an appealing and culturally appropriate form of therapy for Native Americans. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing. It is particularly relevant for those who do not have immediate access to traditional healers or are wary of mainstream behavioral/mental health facilities heavily influenced by Western psychological constructs.

I will conduct the research primarily with the behavioral health treatment staff, including the Native Medicine staff working with the behavioral health department of the Chinle Comprehensive Health Care Facility (CCHCF) in Chinle, AZ. I have permission from the head of the art therapy department, Dr. Gaelynn Wolf Bordonaro, at Emporia State University to conduct the thesis study from afar, finishing my final internship hours at CCHCF if necessary. The Emporia State University IRB has given approval for the thesis research at CCHCF of which I am now asking for final approval from the Navajo Nation IRB.

I will act as a field researcher to obtain data and information. I will collect data for information on perspectives through the phenomenological methods of interviewing and participant observations. The interview setting and methodology for obtaining information will

have an emic focus; participants will have a role in how and when the information is obtained. While collecting data I will use progressive focusing. I will use the data collected through observation to create questions for the interviews.

I will seek out a minimum of five CCHCF Behavioral Health staff, one school counselor whom CCHCF Psychiatrist Dr. Cabrera works with at Chinle, AZ public schools, and a man and woman from the CCHCF Native Medicine staff to volunteer as subjects for in-person, open-ended interviews covering topics such as their profession, their thoughts on working in a behavioral health facility using integrative methods, and their reflections on art therapy as a form of treatment. During the separate individual interviews I will administer the scribble technique, providing the participants with an opportunity to experience an art therapy directive. Once they have completed the scribble technique I will continue the interview and answer questions the participants may have about art therapy. I will record the interviews through notes and/or a recording device with permission, and make appropriate plans to destroy or store the tapes upon completion of the study.

In addition to the qualitative data collected through the interviews, if time allows, I will seek a minimum of six behavioral health treatment staff from CCHCF and school counselors from the Chinle, AZ schools Dr. Cabrera works with, to volunteer to make an art piece with a reflective artist statement, song, or poem for an art exhibit. I will ask the staff to make the art piece as a reflection or representation of their specific roles in behavioral health. The behavioral health treatment staff will determine if they would like to keep their identities confidential for the art exhibit. I will obtain permission, in the informed consent forms, to exhibit the artwork on the Navajo Reservation and at Emporia State University. After the art exhibits have taken place the artwork will be returned to each participant. Permission to take photos of the artwork, artist

statements/songs/poems, the CCHCF facility and grounds, and the staff of CCHCF will be requested in the informed consent document.

### **Part One: Community Involvement**

#### **1. Locations where project will be conducted**

The project will be conducted in Chinle, Arizona. Most of the interviewees will be Behavioral Health treatment staff as well as Native Medicine staff at the Chinle Comprehensive Health Care Facility (CCHCF), some may be school counselors from Chinle whom the CCHCF staff work with.

#### **2. How community members have been involved in the planning of the research/evaluation project**

I have asked CCHCF Psychiatrist Joshua Cabrera for initial permission to conduct the study, and whether the site would have the variety of treatment staff I was interested in working with. Dr. Cabrera agreed for the study to take place, identifying the specific titles of the CCHCF Behavioral Health treatment staff and asking one of the traditional practitioners at the CCHCF whom he sends referrals if she would be interested in taking part in the interviews. Dr. Cabrera also suggested interviewing local school counselors as well for a greater variety, as he too visits the schools each month offering his services and is familiar with the treatment staff.

#### **3. Description of how the community members will be involved in the implementation of the research/evaluation project**

I will ask the CCHCF Behavioral Health and Native Medicine treatment staff and area school counselors with whom Dr. Cabrera works, to volunteer for the interviews, and CCHCF Behavioral Health treatment staff to volunteer for the art making/art exhibit if time allows.

#### **4. Description of how plan to provide findings of the study/evaluation to health care providers, community agencies, schools, chapters, or other interested persons**

I will give a copy of the final summary, my thesis, as well as copies of the interviews, and the art from the art exhibit and scribble drawing directives (unless the individuals want their art piece or scribble drawing returned upon completion of the study) to the Navajo Nation Institutional Review Board, the Navajo Nation Department of Behavioral Health, and the CCHCF Department of Behavioral Health. The findings will be available to interested parties. If CCHCF is interested in watching a final presentation upon completion of the study, I can put one together.

#### **5. Briefly explain how you plan to provide technical assistance to the community (writing grants, conducting in-service training sessions, developing educational materials, assisting with the annual community research conference and/or donation of equipment**

I am not certain of what technical assistance I am qualified to provide the community. I will provide services in whatever way I am able.

### **Part Two: Benefits To The Navajo Nation**



**6. Explain specifically how the results of your study will be used to improve the health status of the Navajo People.**

The study will help the behavioral health treatment staff better understand their roles in a treatment team, how their specific training can better help the healing process in interaction with the other behavioral/mental health practitioners, enhancing the effectiveness of the patients' recovery process and behavioral/mental health maintenance overall.

**7. Has this research been conducted elsewhere? If so, explain what the results were.**

If it has, I am unaware of it.

**8. Has the study been conducted on the Navajo reservation? If so, explain what the results were.**

Not that I am aware of.

**9. Has the study been coordinated with similar studies currently being conducted? If so, explain what plans will be made to ensure that necessary coordination occurs and duplication is eliminated.**

No, the study is not coordinated with other studies.

**Part Three: Research Project Description**

**10. Describe the background and rationale for your research/evaluation project.**

I like the idea of interviewing treatment staff rather than the patients. Most studies use the patients as measures of the effectiveness of a treatment method, ignoring staff perceptions. This study will help the staff to understand more thoroughly how each member helps in the healing process, resulting in clarification of each specific role, rather than relying on assumptions of what each member does. The study encourages the participants to self-reflect on their role as a behavioral health facilitator, what their perceptions are of how they help facilitate behavioral health, what they have to offer the patients, how their specific skill set can be used the most effectively when working with the other staff, and so forth.

**11. State the aims, objectives, and/or hypothesis of your proposed research or evaluation project.**

The purpose of this proposed qualitative study is to better understand the specific roles of each member of the behavioral health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each behavioral health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans. The hypothesis is that art therapy is an appealing and culturally appropriate form of therapy for Native Americans. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing. It is particularly relevant for those who do not have immediate access to traditional healers or are wary of mainstream behavioral/mental health facilities heavily influenced by Western psychological constructs.

**12. Describe the targeted participants who will be recruited for your project.**

I will seek out a minimum of five CCHCF Behavioral Health staff to volunteer as subjects for in-person, open-ended interviews covering topics such as their profession, their thoughts on working in a behavioral health facility using integrative methods, and their reflections on art therapy as a form of treatment. In addition to the qualitative data collected through the interviews, if time allows, I will seek a minimum of ten Behavioral Health treatment staff from the interviews to volunteer to make an art piece with a reflective artist statement, song, or poem for an art exhibit. I will ask the staff to make the art piece as a reflection or representation of their specific roles in behavioral health.

**13. Explain the procedures to be used for the participant recruitment, the selection criteria, and the exclusion criteria.**

I am working with Dr. Joshua Cabrera to identify specific mental health treatment staff, and both he and I will be asking them if they are interested in participating in the study. The criteria for the study is that each participant has training in some form of mental/behavioral health treatment, whether it be as a counselor, psychologist, social worker, psychiatrist, peer support specialist, art therapist, or traditional healer. Each practitioner must have been working in the field for at least one year prior to the interviews for the study.

**14. Explain the nature and procedures, if any, to be used for incentives for participation.**

The only incentive offered will be for the behavioral health staff to have a better understanding of one another and time to reflect on her or his specific role as a facilitator of behavioral health. If time permits, the participants may also enjoy creating an art piece.

**15. Describe the methods and the procedures for the study design, sampling, data gathering, data analysis, and plans for reporting the study results.**

I will act as a field researcher to obtain data and information. I will collect data for information on perspectives through the phenomenological methods of interviewing and participant observations. The interview setting and methodology for obtaining information will have an emic focus; participants will have a role in how and when the information is obtained. While collecting data I will use progressive focusing. I will use the data collected through observation to create questions for the interviews.

**16. Describe the type and content of instrument (s) to be used for data collection. Copies of all instrument (s) to be used must be attached to your IRB application.**

Description of Scribble Technique

The scribble technique is a projective assessment technique developed independently in the 1940s by two individuals; the American art teacher and artist Florence Cane and British psychoanalyst and pediatrician Donald W. Winnicott. Winnicott called it the squiggle game and used it with his child patients to get to know what was on the mind of the child as quickly as possible (Rubin, 2005). Cane referred to it as the scribble drawing, or scribble technique, and used it to facilitate spontaneous expression and help release imagery dormant in the participants' unconscious (Rubin, 2005). Cane's experience as a dancer influenced her inclusion of movement and breathing exercises as part of the warm-up to the scribble drawing technique. The scribble technique has been adopted by many art therapists to establish rapport with participants through a decrease in anxiety and resistance (Rubin, 2005).

Participants are given a blank piece of paper (roughly 8 ½" x 11" or larger) and colored pencils, crayons, markers, or pastels (many types of media can be used). They are then asked to swing their arms around freely, while moving their body and scribbling in the air. After the participants have loosened their bodies they are asked to close their eyes and scribble on the piece of paper in front of them. Sometimes, the same directives above are given but participants are allowed to keep their eyes open; in this case they are often asked to use their non-dominant hand, or the body movement portion is skipped (Rubin, 2005).

Once the participants are finished with the scribbles they are asked to look at the scribbles from different angles. They are asked to find an image or images that can be seen in the scribbles. They are then asked to develop these formal images into a more concrete picture by omitting scribble lines in different places, covering up spaces, and adding new lines, shapes, and colors if necessary, so others are able to clearly see the same image(s). The participants are then invited to talk about what significance and meaning the image has for them (Rubin, 2005).

Rubin, J. A. (2005). *Artful therapy*. Hoboken, New Jersey: John Wiley and Sons.

#### **Part Four: Informed Consent Form**

**17. A copy of the Informed Consent Form must be attached to your IRB application that fully describes procedures to be used for Informed Consent to protect study participants from injury or harm or breach of confidentiality.**

- a. Disclose the purpose of the research
- b. State the expected duration of the subject's participation;
- c. Describe the procedures to be followed, including the collection and testing of specimen, any reasonably foreseeable risks or discomforts to the participants
- d. Describe the collection of any specimens (blood/tissue/hair/bodily fluids)
- e. Name any benefits from the research to the participants or others:
- f. Describe the extent to which confidentiality of records identifying the participant will be protected
- g. Identify an individual to contact for answers to questions about the research and research participant's rights, The contact person for the Navajo IRB Office is: Beverly Becenti-Pigman, Board Chair, Navajo IRB Office. Navajo Division of Health, PO Box 1390 Window Rock, AZ 86515. Telephone number is (928) 871-6650. Fax number is (928) 871-6259.
- h. Identify a person to contact in the event of a research related injury to the participant, and;
- i. Reiterate that participation in the research/evaluation is voluntary, and shall not interfere with services available to the rest of the population
- j. Explain any potential physical risks, psychological risks or discomforts to the participants that may be associated with or that may result from participation in your research project

## INFORMED CONSENT DOCUMENT

I, J. Olivia Drumm am a graduate art therapy student at Emporia State University (ESU) in Emporia, Kansas. I am conducting a research study to better understand the specific roles of each member of the Behavioral Health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans. The study will help the behavioral health treatment staff better understand their roles in a treatment team, how their specific training can better help the healing process in interaction with the other behavioral health practitioners, enhancing the effectiveness of the patients' recovery process and behavioral health maintenance overall. This research will form the basis of my master thesis; the final requirement toward earning a Master's of Science in Art Therapy.

The Department of Psychology at Emporia State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided for you to decide whether you wish to participate in the present study. Be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach. Likewise, if you choose not to participate, you will not be subjected to reprimand or any other form of reproach.

I will conduct informal interviews. I will take notes and record the interview(s) with a tape recorder or other type of recording device available. The interview(s) may take from fifteen minutes to three hours. I will take photographs of participant artwork, research tools, and the CCHCF Behavioral Health treatment facility. I will use pseudonyms to maintain confidentiality. Copies of recorded information will be given to the Navajo Nation Institutional Review Board and the Navajo Nation Department of Behavioral Health. My personal copies will eventually be destroyed (tapes erased, papers burned). All recorded information for the research project will be kept in a locked compartment of my car and in a secure filing box in my current place of residence in Shiprock, NM.

If time permits, you have the option to create an art piece and artist statement, poem, or song over your reflection of self as healer/therapist/behavioral health facilitator. The artwork and artist statements/poems/songs created as reflection of self as healer/therapist/behavioral health facilitator will be exhibited. Participants have the option to have their identities displayed with their art pieces and artist statements or to have the identities remain confidential. I will discuss and confirm identity confidentiality with each participant before exhibiting her or his artwork.

I will present the results of the study as my Master's thesis at Emporia State University. I will use participants' artwork, artist statements, interview responses, and photos for the art exhibit and educational purposes. Identifying data (participant name, photo, etc.) will be kept confidential upon request. The artwork will be returned after an art exhibit on the Navajo Reservation and at Emporia State University.

**If you have further questions, you may contact the Navajo Nation IRB:**

Beverly Becenti-Pigman  
Board Chair, Navajo IRB Office  
Navajo Division of Health  
PO Box 1390  
Window Rock, AZ 86515

Phone: (928) 871-6650  
Fax: (928) 871-6259

**You may contact me at:**

J. Olivia Drumm  
PO Box 834  
Shiprock, NM 87420

E-mail: [jdrumm@emporia.edu](mailto:jdrumm@emporia.edu)  
Phone: 314-223-1462.

**You may also contact the head of the art therapy department at ESU:**

Dr. Gaelynn P. Wolf Bordonaro  
Campus Box 4031  
Emporia State University  
1200 Commercial  
Emporia, KS 66801-5087

Email: [gwolf@emporia.edu](mailto:gwolf@emporia.edu)  
Phone: (620) 341-5809

The contact person for the Navajo IRB Office is:

*"I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."*

\_\_\_\_\_

Subject

\_\_\_\_\_

Date

\_\_\_\_\_

Guardian Consent

\_\_\_\_\_

Date

Appendix F

Approval Letter of Resolution Canyon De Chelly Comprehensive Health Services, INC.

(CDCCHS), Board of Directors



## CANYON DE CHELLY COMPREHENSIVE HEALTH SERVICES, INC.

### RESOLUTION OF THE CANYON DE CHELLY COMPREHENSIVE HEALTH SERVICES, INC.

CDCCHS.011211

Supporting Emporia State University Graduate Student, J. Olivia Drumm, to conduct the proposed research entitled "Utilizing art therapy for healing as part of an integrative mental health treatment team: Interviews from the Navajo Reservation" to better understand the specific roles of each member of the mental health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

#### WHEREAS:

1. The Canyon De Chelly Comprehensive Health Services, Inc. (CDCCHS) is vested with authority to make local ordinances, approve plans and take positions on matters of local concern that are in the best interest of 16 Chapter communities of the Navajo Nation served by the Navajo Area Indian Health Service, Chinle Service Unit; and
2. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing.
3. It is particularly relevant for those who do not have immediate access to traditional healers or are wary of mainstream mental health facilities heavily influenced by Western psychological constructs.
4. A minimum of five Chinle Comprehensive Health Care Facility (CCHCF) mental health staff will be sought out to volunteer as subjects for in-person, open-ended interviews covering topics such as their profession, their thoughts on working in a mental health facility using integrative methods, and their reflections on art therapy as a form of treatment.
5. During the separate individual interviews, the scribble technique will be administered, providing the participants with an opportunity to experience an art therapy directive.
6. Interviews will be recorded through notes and/or a recording device with permission, copies of the recorded information will be turned in to the Navajo Nation Human Research Review Board and Navajo Behavioral Health Department.
7. If time allows, a minimum of five CCHCF mental health staff will be asked to volunteer to make an art piece with a reflective artist statement, song, or poem for an art exhibit;
8. The art piece will be created as a reflection or representation of their specific roles in mental health treatment.

9. The mental health treatment staff will determine if they would like to keep their identities confidential for the art exhibit.
10. Permission will be obtained in the informed consent forms, to exhibit the artwork on the Navajo Reservation and at Emporia State University, take photos of the artwork, artist statements/songs/poems, the CCHCF facility and grounds, and the staff of CCHCF;
11. Once the art exhibits have taken place the artwork will be returned to each participant.
12. Informed consent will be used for all participants; participation in this project is voluntary; information collected will be confidential, and all necessary approvals will be obtained prior to starting the research study, and the Navajo people, IHS, relevant tribal offices and departments will be informed of the results of this study.

**NOW THEREFORE BE IT RESOLVED THAT:**

The Canyon De Chelly Comprehensive Health Services hereby supports Emporia State University Graduate Student, J. Olivia Drumm, to conduct the proposed research entitled "Utilizing art therapy for healing as part of an integrative mental health treatment team: Interviews from the Navajo Reservation" to better understand the specific roles of each member of the mental health treatment team at an Indian Health Service facility on the Navajo Reservation. Primarily focusing on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

**CERTIFICATION**

We hereby certify that the foregoing resolution was duly considered at the meeting of the CDCCHS meeting at Chinle, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of \_\_\_ in favor \_\_\_ opposing \_\_\_ abstaining, this 12<sup>th</sup> day of January 2011.

\_\_\_\_\_  
Chairperson, CDCCHS

Motion by: \_\_\_\_\_  
Seconded by: \_\_\_\_\_



9. The mental health treatment staff will determine if they would like to keep their identities confidential for the art exhibit.
10. Permission will be obtained in the informed consent forms, to exhibit the artwork on the Navajo Reservation and at Emporia State University, take photos of the artwork, artist statements/songs/poems, the CCHCF facility and grounds, and the staff of CCHCF;
11. Once the art exhibits have taken place the artwork will be returned to each participant.
12. Informed consent will be used for all participants; participation in this project is voluntary; information collected will be confidential, and all necessary approvals will be obtained prior to starting the research study, and the Navajo people, IHS, relevant tribal offices and departments will be informed of the results of this study.

**NOW THEREFORE BE IT RESOLVED THAT:**

The Canyon De Chelly Comprehensive Health Services hereby supports Emporia State University Graduate Student, J. Olivia Drumm, to conduct the proposed research entitled "Utilizing art therapy for healing as part of an integrative mental health treatment team: Interviews from the Navajo Reservation" to better understand the specific roles of each member of the mental health treatment team at an Indian Health Service facility on the Navajo Reservation. Primarily focusing on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

**CERTIFICATION**

We hereby certify that the foregoing resolution was duly considered at the meeting of the CDCCHS meeting at Chinle, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of \_\_\_ in favor \_\_\_ opposing \_\_\_ abstaining, this 12<sup>th</sup> day of January 2011.

\_\_\_\_\_  
Chairperson, CDCCHS

Motion by: \_\_\_\_\_  
Seconded by: \_\_\_\_\_

Appendix G

Approval Letter from Chinle Comprehensive Health Care Facility (CCHCF)

Chief Executive Officer Ron Tso, MPH



Chinle Comprehensive Health Care Facility  
Indian Health Service  
P.O. Box PH  
Chinle, Arizona 86503

February 7, 2011

Ms. Beverly Becenti-Pigman, Chair  
Navajo Nation Human Research Review Board  
Navajo Division of Health  
P.O. Box 1390  
Window Rock, Arizona 86515

Dear Ms. Becenti-Pigman,

This is to inform you that I support Ms. J. Olivia Drumm's research proposal to conduct a study entitled: *"Utilizing art therapy for healing as part of an integrative mental health treatment team: Interviews from the Navajo Reservation"*. Ms. Drumm is a graduate student at Emporia State University and she will be conducting the proposed study at Chinle Service Unit including Chinle Comprehensive Health Care Facility, Pinon Health Center and Tsaille Health Center where mental health providers work.

Olivia presented her study to the Board of Directors of the Canyon De Chelly Comprehensive Health Services, Inc. (CDCCHS) on January 12, 2011 whereby a resolution of support was passed. The purpose of the study is to better understand the specific roles of each member of a mental health treatment team, how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

The findings of this study will be useful to all mental health providers as they work with patients using art therapy as a mental health intervention. As you know, art is central to Native American values and evaluating the use of art therapy in mental health services will be beneficial.

Sincerely,

Ron Tse, MPH  
Chief Executive Officer

Appendix H

Resolution of Approval Chinle Chapter Government of The Navajo Nation

# Chinle Chapter Government

THE NAVAJO NATION

**LEO R. BEGAY**  
PRESIDENT

**BRUCE C. DRAPER**  
VICE PRESIDENT

**PRISCILLA M. CLARK**  
SECRETARY/TREASURER

**Leonard H. Pete**  
COUNCIL DELEGATE

**Eugene Tso**  
GRAZING REPRESENTATIVE

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## RESOLUTION OF THE CHINLE CHAPTER NAVAJO NATION CHIN-MAY-11-043

### SUPPORTING AND APPROVING MS. J. OLIVIA DRUMM TO CONDUCT RESEARCH IN THE CHINLE COMMUNITY RELATED TO HER MEDICAL HEALTH RESEARCH WITH THE CHINLE COMPREHENSIVE HEALTH CARE FACILITY.

#### WHEREAS:

1. The Chinle Chapter, a recognized local government of the Navajo Nation, vested with the power and authority to advocate on behalf of its constituents for the improvement of health, safety, general welfare; and
2. Pursuant the Canyon de Chelly Comprehensive Health Service Inc., resolution CDCCHS.011211 has supported Ms. J. Olivia Drumm to conduct research in the Chinle Community; and
3. Pursuant the Navajo Nation Institute Review Board Committee resolution NNR-10.86T has also approved and supported Ms. J. Olivia Drumm to conduct research; and
4. The purpose of the research is to focus on how an art therapist fit into the treatment team and the desirability of using art therapy with Native American patients.

#### NOW, THEREFORE BE IT RESOLVED THAT:

1. The Chinle Chapter hereby supports and approves J. Olivia Drumm to conduct research in the Chinle Community related to her medical health research with the Chinle Comprehensive Health Care Facility.

P.O. BOX 1809 • CHINLE, ARIZONA 86503 • chinle@navajochapters.org  
928/674-2052 • FAX: 928/674-2079

**SUPPORTING AND APPROVING J. OLIVIA DRUMM TO CONDUCT RESEARCH IN THE CHINLE COMMUNITY RELATED TO HER MEDICAL HEALTH RESOURCE WITH THE CHINLE COMPREHENSIVE HEALTH CARE FACILITY.**

**CERTIFICATION**

We, hereby certify that the foregoing chapter resolution was duly considered by the Chinle Chapter at a duly called meeting in Chinle, Navajo Nation (Arizona) at which a quorum was present and that the same was passed by a vote of 25 in favor, 00 opposed and 00 abstained, this 22<sup>nd</sup> day of May, 2011.

Motioned by: Leonard Pete

Leo R. Begay  
Leo R. Begay, Chapter President

Bruce C. Draper  
Bruce C. Draper, Vice President

Priscilla M. Clark  
Priscilla Clark, Secretary/Treasurer

Second by: Eugene Tso

Leonard H. Pete  
Leonard H. Pete, Council Delegate

Eugene Tso  
Eugene Tso, Grazing Representative

Appendix I

Approval Resolution of the Governing Board of Chinle Unified School District NO. 24



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CHINLE UNIFIED SCHOOL DISTRICT NO. 24

Office of the Superintendent

**RESOLUTION OF THE GOVERNING BOARD  
OF CHINLE UNIFIED SCHOOL DISTRICT NO. 24**

Supporting Emporia State University Graduate Student, J. Olivia Drumm, to conduct the proposed research entitled "Utilizing art therapy for healing as part of an integrative mental health treatment team; Interviews from the Navajo Reservation" to better understand the specific roles of each member of the mental health treatment team at an Indian Health Service facility on the Navajo Reservation. The focus will be on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

**WHEREAS:**

1. The Chinle Unified School District No. 24 is vested with authority to make local ordinances, approve plans and take positions on matters of local concern that are in the best interest of 16 Chapter communities of the Navajo Nation served by the Navajo Area Indian Health Service, Chinle Service Unit; and
2. Art therapy can function as a bridge or intermediary mode of therapy for indigenous populations with a deep-rooted belief in traditional healing.
3. It is particularly relevant for those who do not have immediate access to traditional healers or are wary of mainstream mental health facilities heavily influenced by Western psychological constructs.
4. A minimum of five Chinle Comprehensive Health Care Facility (CCHCF) mental health staff will be sought out to volunteer as subjects for in-person, open-ended interviews covering topics such as their profession, their thoughts on working in a mental health facility using integrative methods, and their reflections on art therapy as a form of treatment.
5. During the separate individual interviews, the scribble technique will be administered, providing the participants with an opportunity to experience an art therapy directive.
6. Interviews will be recorded through notes and/or a recording device with permission, copies of the recorded information will be turned in to the Navajo Nation Human Research Review Board and Navajo Behavioral Health Department.
7. If time allows, a minimum of five CCHCF mental health staff will be asked to volunteer to make an art piece with a reflective artist statement, song, or poem for an art exhibit;
8. The art piece will be created as a reflection or representation of their specific roles in mental health treatment.
9. The mental health treatment staff will determine if they would like to keep their identities confidential for the art exhibit.
10. Permission will be obtained in the informed consent forms, to exhibit the artwork on the Navajo Reservation and at Emporia State University, take photos of the artwork, artist statements/songs/poems, the CCHCF facility and grounds, and the staff of CCHCF;

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P. O. Box 587, Chinle, Arizona 86503 • (602) 674-9600 • Fax (602) 674-9608



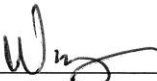
11. Once the art exhibits have taken place the artwork will be returned to each participant.
12. Informed consent will be used for all participants; participation in this project is voluntary; information collected will be confidential, and all necessary approvals will be obtained prior to starting the research study, and the Navajo people, IHS, relevant tribal offices and departments will be informed of the results of this study.

**NOW THEREFORE BE IT RESOLVED THAT:**

The Chinle Unified School District No. 24 Governing Board hereby supports Emporia State University Graduate Student, J. Olivia Drumm, to conduct the proposed research entitled "Utilizing art therapy for healing as a part of an integrative mental health treatment team: Interviews from the Navajo Reservation" to better understand the specific roles of each member of the mental health treatment team at an Indian Health Service facility on the Navajo Reservation. Primarily focusing on how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

**CERTIFICATION**


We hereby certify that the foregoing resolution was duly considered at the meeting of the Governing Board in Chinle, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of 4 in favor, 0 opposing 0 abstaining, this 13<sup>th</sup> day of July 2011.

  
\_\_\_\_\_  
Wayne Claw, President

\_\_\_\_\_  
Virgil Brown, Jr., Member

\_\_\_\_\_  
Rose W. Martinez, Member

  
\_\_\_\_\_  
Joyce V. Nez, Member

  
\_\_\_\_\_  
Paul Guy, Jr., Member

Appendix J

Letter of Approval from Superintendent of the Chinle Unified School District

Dr. Jesus V. de la Garza

June 30, 2011

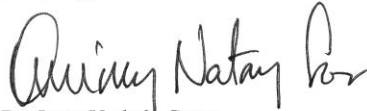
Dear Chair Becenti-Pigman and Members of the Board,

I am writing this letter as an approval for Emporia State University Graduate Student, J. Olivia Drumm to conduct the study, **NNR-10.86T Utilizing art therapy for healing as part of an integrative mental health treatment team: Interviews from the Navajo Reservation**, at the CDCCHS, Inc. site in Chinle, AZ and other sites with mental health providers operating under CDCCHS.

Olivia presented her study at the June 30, 2011 Chinle, Arizona School Board meeting. The purpose of the study as presented to us, is to better understand the specific roles of each member of a mental health treatment team, how an art therapist fits into the treatment team and the perceptions of each mental health facilitator about art therapy and their evaluations over the desirability of using art therapy with Native Americans.

- A minimum of five (CDCCHS) mental health staff and Chinle school district school counselors will be sought out to volunteer as subjects for in-person, open-ended interviews covering topics such as their profession, their thoughts on working in a mental health facility using integrative methods, and their reflections on art therapy as a form of treatment.
- During the separate individual interviews, the scribble technique will be administered, providing the participants with an opportunity to experience an art therapy directive.
- Interviews will be recorded through notes and/or a recording device with permission, copies of the recorded information will be turned in to the Navajo IRB and Navajo Behavioral Health Department.
- If time allows, a minimum of five (CDCCHS) mental health staff and Chinle school district school counselors will be asked to volunteer to make an art piece with a reflective artist statement, song, or poem for an art exhibit; the art piece will be created as a reflection or representation of their specific roles in mental health treatment.
- The mental health treatment staff will determine if they would like to keep their identities confidential for the art exhibit.
- Permission will be obtained in the informed consent forms, to exhibit the artwork on the Navajo Reservation and at Emporia State University, take photos of the artwork, artist statements/songs/poems, the (CDCCHS) facility and grounds, and the staff of (CDCCHS)

Sincerely,



Dr. Jesus V. de la Garza  
Superintendent of the Chinle Unified School District

Appendix K

Letter intended for the Navajo Nation IRB quarterly report regarding the study, written  
by CCHCF Behavioral Health Department Director



Chinle Comprehensive Health Care Facility  
Indian Health Service  
P.O. Box 100  
Chinle, Arizona 86501

September 19, 2011

Navajo Nation IRB Chairwoman  
Beverly Becenti-Pigman

Y'ah'tee and warmest greetings from Chinle, Arizona.

My role here is as therapist, department director, and child psychiatrist. I have lived and worked in Chinle for six good years of my life.

Olivia Druum invited me to comment on the influence of her research project on current staff activities, and this letter summarizes my thoughts on the matter.

"What is the point of greatest urgency?" This remains a valuable question to know at the onset of therapy. Likewise, it is the starting point of my response. The point of greatest urgency for our department is unity. Lack of harmony within impairs everything we put our hand to. The most sophisticated plan or labored strategic vision will limp painfully along (and then be shot and put out its misery as a faded memory) unless unity is achieved. Unity is the beginning of coordinated activity, health, and effectiveness.

A lack of unity is sustained in the following manner; cultural conflicts are avoided, staff members segregate themselves into their comfortable peer groups, and the work is also segregated, doctors go here, psychologist there, therapist over there, and so on.

To cross the canyons between us, we must first acknowledge that they exist. This is facilitated through creating a holding environment (Winnicott) where we can discuss the cultural divide as it is, as who we are, without an excess of fear. Some anxiety will be present and unavoidable, for the cultural gap between Iowa or Texas and Diné is vast.

If a holding environment is created, the next step is to develop a forum. As we are in the practice of therapy, the forum immediately available is "culture and the practice of therapy". After this, a language is developed that reflects the repeated themes that this forum returns to. During this discussion, one staff member presents a case where culture had a very strong impact. All of us participate, including all Diné staff. Through this, unity is strengthened, as we as a group face those canyons and decide to stretch as far as we can to each other.

Where does Olivia's work fit into this? Olivia's questions, and her responses, catalyzed the creation of this forum. How did they do this? She asked us as a staff to think about culture and to express our views to her. Also, in our discussion, she reacted to my responses vigorously, probing me further regarding my beliefs on culture. In a subsequent discussion, we both acknowledged that if left unsaid, cultural conflict remains a potent source of pain for both Native Americans and Whites. The conflict appeared between us at the time of the interview.

I believe that a frank discussion of the issues of culture were also on Olivia's mind when she generated her questions. I had the opportunity to informally discuss some of her experiences as a teacher, where these powerful, unacknowledged undercurrents swept away reason and unity in the departments that she worked in.

Appendix L

Participant Personal Identity Table

<u>PARTICIPANT</u>	<u>ETHNIC IDENTITY</u>	<u>CULTURAL IDENTITY</u>	<u>PRIMARY LANGUAGE(S)</u>	<u>SECONDARY LANGUAGE(S)</u>	<u>SPIRITUAL BELIEFS</u>	<u>PLACE (S) RAISED, LIVED</u>	<u>PLACES TRAVELLED</u>
1. CCHCF Behavioral Health Department Director and Child Psychiatrist, AGE 39 MALE	European Hispanic (Cuba, Mexico)	Modern Western Medical Culture, (Branch off of Scientific)	English	Spanish	Raised Southern Baptist,  Explored Different Religions Such as Sufism And Buddhism,  Beliefs Work In progress	Raised in Texas  Lived Louisiana, Kentucky, Oregon, Arizona	Mexico, Hong Kong, China, Canada, Cuba, Much of The United States
2. Psychiatrist, Specialization in Music Therapy and Core Shamanism AGE 48 FEMALE	European (Irish, English, Austrian, French) Orthodox Jewish, Cherokee	“Euro-mutt”	English	Introductory Yiddish, French, German, Spanish	Raised Catholic,  Practiced Tibetan Buddhism, Core Shamanism  Thought of Self as “religious nut”	Raised in California And Parts of Europe (Belgium, England, Germany)  Lived In different parts of USA Including Arizona	Different parts of Europe  Wasn’t specific but several states in the United States
3. Psychiatrist, AGE 59 MALE	European Swiss Amish Mennonite	Western Scientific, Liberal Humanitarian	English	Spanish, German, Navajo	Raised In Traditional Mennonite Community,  Agnostic	Raised in Kansas  Lived Indiana Ohio, Maryland, Pennsylvania , Arizona, the Chaco (located at common borders of Paraguay And Argentina)	Much of The United States, Brazil
4. Clinical Psychologist, AGE 54 MALE	European Anglo Saxon (German, Scottish, English)	Western, Multi-Racial Family	English	Greek, German, Introductory Navajo	Raised Protestant,  Grace Bible Community Church	Raised in Oregon  Lived North Dakota, Montana, Alaska, Arizona	Florida, California, Utah, Texas, Washington, Idaho
5. Clinical Psychologist, AGE 68 MALE	European (Scottish, Irish, Cherokee	Normal Comfortable Being,  Didn’t like To label self,  On earth to inform God about creation and all of its aspects  Deviant in reality and perceptions comparatively to others	English	German, Introductory Spanish	Raised Southern Baptist,  Practiced Community of Christ Church	Raised in Aruba  Lived Grand Cayman, Arizona, Colorado, Alabama, Georgia	Much of Eastern United States, Jamaica, Columbia, Cuba, Mexico, Caribbean



<u>PARTICIPANT</u>	<u>ETHNIC IDENTITY</u>	<u>CULTURAL IDENTITY</u>	<u>PRIMARY LANGUAGE(S)</u>	<u>SECONDARY LANGUAGE(S)</u>	<u>SPIRITUAL BELIEFS</u>	<u>PLACE (S) RAISED, LIVED</u>	<u>PLACES TRAVELLED</u>
6. Substance Abuse Counselor/ Mental Health Specialist, AGE 55 FEMALE	Navajo	Traditionalist (Navajo)	Navajo	English Introductory Spanish	Raised With Traditional Navajo Beliefs	Raised in Arizona on Navajo Reservation  Lived On the Navajo Reservation	Every state comprising the United States
7. Social Worker Supervisor, AGE 52 FEMALE	Navajo	Bi-cultural Or Two Different Worlds, Traditional Navajo And Mormon Foster Families (Western)	Navajo	English	Raised With Traditional Navajo Beliefs And Mormon Church  Practiced Mormonism	Raised on the Navajo Reservation, In California (with foster families),  Lived New Mexico (off the reservation), Utah, Alaska	Alaska, California, Texas, Oregon, Oklahoma Throughout the Western part of the United States, Mexico (with foster parents)
8. Medical Social Worker, AGE 40 MALE	Navajo	Bi-cultural, Western And Navajo Traditional	Navajo	English	Raised With Traditional Dine (Navajo) Beliefs, Native American Church (NAC), Catholicism, And Mormonism  Practiced "bits and pieces" of each religion was raised	Raised in Arizona on the Navajo Reservation, Utah (Mormon foster family)  Lived Arizona, Utah	Utah, New Mexico, Colorado, Kansas, Washington D.C.
9. Medical Social Worker/Mental Health Specialist AGE 53 FEMALE	Navajo	Traditional In two worlds, Western (professional) Traditional Navajo	Navajo	English	Raised With Traditional Navajo Beliefs But Was Never Explained  Spirituality classes in college  Practiced Christianity, Traditional Navajo Beliefs	Raised in Arizona on the Navajo Reservation  Lived Utah, Oklahoma, Nevada	Travelled within the states
10. Medical Social Worker/Mental Health Counselor AGE 59 FEMALE	Navajo	Traditional Navajo	Navajo	English, Spanish	Raised With Traditional Navajo Beliefs Also Attended Baptist Church  Practiced Traditional Navajo Beliefs	Raised in Arizona on the Navajo Reservation  Lived Arizona, New Mexico, Montana, Utah, Washington, Canada, Mexico (College Exchange Program)	Louisiana, Canada, New York, Washington D.C.  Much of the Western United States
<u>PARTICIPANT</u>	<u>ETHNIC</u>	<u>CULTURAL</u>	<u>PRIMARY</u>	<u>SECONDARY</u>	<u>SPIRITUAL</u>	<u>PLACE (S)</u>	<u>PLACES</u>

	IDENTITY	IDENTITY	LANGUAGE(S)	LANGUAGE(S)	BELIEFS	RAISED, LIVED	TRAVELLED
11. Graduate Student Intern, AGE 38 FEMALE	Navajo	Traditional Navajo	Navajo	English	Raised With Traditional Navajo Beliefs And Catholicism  Practiced Traditional Navajo Beliefs	Raised in Arizona on the Navajo Reservation  Lived Arizona Off the Reservation	Not addressed
12. Junior High School Counselor, AGE 43 MALE	Navajo, Mescalero Apache	Native American, Mostly Navajo, Negotiating Two different tribal affiliations And Cultural Constructs  Two worlds Native And Western	Navajo	English, Introductory Apache, Spanish	Raised Without Specific Beliefs Views "religion" as Western or mainstream concept  Raised with Nature Oriented Spirituality, Respect for the Environment, Native Beliefs, NAC (Native American Church)  Practiced Nature Oriented Spirituality, Respect for the Environment, Native Beliefs	Raised in Arizona on and off the Navajo Reservation  Lived Washington D.C. (summer internship), Alaska (seasonal summer job), New Mexico, California, Arizona	Mexico, Belgium, Colorado, Oklahoma, Texas, Vermont, Massachusetts, New Hampshire, North Carolina, Several parts Of the United States (for work)
13. Elementary School Counselor, AGE 64 FEMALE	European Italian, German	Apple Pie American	English	Spanish, Introductory Navajo	Raised Lutheran,  Identified as Christian, did not belong to a religion	Raised in Ohio  Lived Arizona, Illinois, Ohio	Italy, Alaska, Washington, Montana, Virginia, New York

Appendix M

Emporia State University IRB Letters of Approval