Snow Snakes: An Art Therapy Decolonization Project with a Native American Community

by

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Abstract

This article-style dissertation describes participatory action research that combined art therapy with narrative therapy to meet the specific cultural needs of Native American research to achieve a transformative outcome. The study sought to rebuild a traditional cultural connection within A community in such a way that would support personal and communal healing. A connection to the participants' specific Native American culture was provided through myth, story, and art that reflected their culture, with the goal of creating a greater sense of self-esteem and an embrace of their culture.

Culturally grounded methods for identifying and measuring outcomes, and demonstrating their effectiveness, was developed in close collaboration with Native elders and community partners. Through a series of focus groups, community members defined an outline for culturally relevant treatment and success for a specific Native American community.

Results of the study suggest that community-based art therapy within participatory action research strengthened the spiritual, personal, and social development of the co-researchers, as well as made a difference of cohesion within the community.

Dedication

I dedicate my dissertation work to my family and dear friends. My beloved children, Warren, Colonel, and Blake have been caring and helpful throughout the entire process and are ready to get on with calling me Dr. Mom. Most certainly my dedication must go to my biggest cheerleader, Diane Rust, who patiently listened while I talked about my research, endlessly. A special feeling of gratitude goes to my mentor and my most constant cheerleader, Paul Gibeau, and to my compassionate mentor Gloria Jean Johnston. I could never have done this without the love and support of all of these people.

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CHAPTER 1: INTRODUCTION TO THE PROJECT

The documents that follow this introduction form the contents of an article-style dissertation in art therapy. The first two articles, which disseminate results of participatory action research, are reflective of a larger interest in such methodology and in my work cross-culturally as an art therapist working in a Native American community. The third article is a reflection on my personal journey of thoughtful liberation through my deep community work within the Native American community while working on this doctoral research. I found little room in the two research articles for a description of what I feel has been a profound journey within the context of my doctoral studies, and decided that my personal journey may be of use to other therapists; hopefully, as affecting and thought-provoking for other therapists as it was for me.

I work as an art therapist offering outpatient mental healthcare outside of my own culture within a Native American community mental health facility in Northern Wisconsin. My practice-based research began as an interest in studying traditional Potawatomi stories and responsive art creations as a culturally appropriate method for addressing the needs of the community, building community cohesiveness and historical knowledge of culture, and increasing the art therapy knowledge base in a cross-cultural setting. My goal was to bridge Western psychological theory and Euro-centric therapeutic models, in which much of art therapy is based, with Native American narrative models of healing as understood by Potawatomi and Ojibwa community members with whom I worked.

My research interest was in developing a culturally sensitive art therapy practice modality, combining Potawatomi and Ojibwa cultural and historical teaching stories with art making as a therapeutic response to intergenerational trauma. I wanted to combine traditional, spiritual, and

cultural Potawatomi and Ojibwa therapeutic and educational narrative practices with the mainstream therapeutic based psychological treatment theory within art therapy.

In my practice I must consider the impact an art-based intervention might have in light of possible continuing colonization. This self-reflexive questioning of intent and imposition has been constant in my cross-cultural practice. As I have gradually strengthened my relationships with the leaders of the tribal community (which is how members self-identify), I have learned that the community is not regularly exposed to the traditional stories that were told in earlier generations. Other cultural information also has been lost, including traditional games (Adams, 1995). I wanted to facilitate culturally sensitive and decolonizing art therapy experiences as an open door, providing the opportunity for participants to find their own meaning. I wanted to look into the spaces between stories and art therapy, and the metaphoric "overlaps" or spaces between talk, art, and narrative therapy. My study sought to rebuild the connection within the Native American community in such a way that would support personal and communal healing. I proposed that a connection to their specific Native American culture, provided through story and art therapy, would help participants embrace their culture and a greater sense of self-esteem would ensue.

The following pages of this introduction to the project provide a detailed overview of the context surrounding the research questions and resulting design, outcomes, and their significance. Readers will find that much of the same information has also been incorporated into Chapters 2, 3, and 4, which are presented in the form of the three articles. Chapter 5 offers a reflection on the project as a whole.

Contextual Background

Intergenerational Trauma and Why History Matters

Few cultures within North America have endured such a sustained assault on their rights, culture, and lives, as Native Americans (Chansonneuve, 2007; Fournier & Crey, 1997). When viewed from the perspective of Native Americans, the onslaught of ethnic cleansing must

have felt like an "unrelenting destruction on a massive scale" (Chansonneuve, 2007, p. 6). Before European contact, an estimated seven million or more Native Americans resided in North America (Chansonneauve, 2007), but within a few years of conquest, more than 90% of the population was dead, whether from smallpox, measles, and influenza, war, theft of property that caused displacement, poverty, and/or starvation (Chansonneauve, 2007; Duran & Duran, 1995). However, it is only within the last 20 years that the intergenerational nature of trauma has been examined with respect to Native American communities (Adams, 1995; Braveheart-Jordan & De Bruyn, 1995; Lederman, 1999; Waldram, 1997, 2004).

Within several tribal communities where I have worked, the idea of intergenerational trauma has only recently gained their interest. Although an ongoing basis for mental health care in Canada (Chansonneauve, 2007; Dutton, 1998), the idea of inter-generational trauma is relatively new in Native communities in the U.S. (Dunbar-Oritz, 2014; Waziyatawin, 2005). Interest is growing in Native American communities; however, I have experienced push-back from people in adjacent White communities, where the concept of intergenerational trauma is not well understood.

Root (1992) wrote that direct personal trauma may result from discrimination, oppression, and racism, naming these experiences "insidious trauma" (p. 1) because subsequent generations often are unaware of their impacts and losses. Root explained that the community becomes inured to the oppression when many community members suffer with the same traumatic history. Described as a "matrix of traumatic experience" (Dutton, 1998, p. 1), the ongoing effect of oppression, racism, and discrimination leads to the view that the world is unsafe for everyone and that response to the fear of not feeling safe becomes dysfunctional, and a trauma itself (Kirmayer,

Brass, & Tate, 2000). Kirmayer et al. (2000) wrote of the effects of trauma for Native Americans:

> The emphasis on narrating personal trauma in contemporary psychotherapy is problematic because many forms of violence against Aboriginal people are structural or implicit and so may remain hidden in individual accounts . . . Individual events are part of larger historical formations that have profound effects for both individuals and communities. (p. 613)

The most recent of 300 years of on-going influences and personal trauma has resulted in assimilation into the prevailing maintstream culture through forced attendance at government sponsored boarding schools in the 19th and 20th centuries (Adams, 1995; Chansonneuve, 2005; Cohen, 2003, Hodgson, 1990; Olson & Wilson, 1986; Witko, 2006). Gagne (1998) and Hodgson (1990) identified the boarding school experience of the late 19th to the mid 20th centuries as a key component in the cycle of trauma experienced by Native Americans. As a result of being forced to attend boarding schools, important components of indigenous culture have been lost and not passed on from the elders to children (Gray & WanmidiWi, 2012).

The boarding schools were founded throughout North America as a colonial strategy that remained in place in the United States until 1977 and in Canada until 1998. The prevailing belief at that time was that Indians were "savages" who needed to become more like their White neighbors (Chansonneauve, 2005). This mandate was based on the notion to "kill the Indian in him and save the man" (Fournier & Cray, 1977, p. 55), meaning to erase Native American culture and replace it with European-based culture. Boarding schools were implemented as a way to educate Native American children away from what were considered the bad influences of their culture through governmental and Christian educational indoctrination (Olson & Wilson, 1986).

During the era of boarding schools, five generations of Native American children lived in boarding schools for most of their childhood (Adams, 1995; Braveheart-Jordan & De Bruyn, 1995; Duran, 2006; Fournier & Crey, 1997; Haig-Brown, 2010; Wilson, 1986). Expected to assimilate into the prevailing White society, children were subjected to beatings if they spoke their native language and were stripped of their cultural heritage and their native clothing, and shamed regarding hair customs, while being called "heathens" and "savages." Children were not allowed to leave these schools until the age of 16, and then were returned to their communities as adults, unfortunately ignorant of the tribal or community language, customs, and their historical cultural heritage (Chansonneuve, 2007; Cohen, 2003, Olson & Wilson, 1986; Witko, 2006). Without knowing about their culturally based traditional family systems, without an understanding of their native heritage, without their traditional religion or language, they had difficulty passing these traditions on to younger generations (Wilson, 1986). Gagne concluded that the effects of the residential school experience were felt beyond the generation that attended the school in that the children of those who attended were often subject to abuse by parents, and who later became abusers themselves (p. 36).

Native American Belief Systems and Healing Traditions

To try to understand how the trauma of attending boarding school continues to affect Native Americans, it may be best to see it through their eyes (Cohen, 2003; Dunbar-Oritz, 2014). In my understanding of an overarching Native American worldview, a core belief is that everything is connected. Another core belief is that things like time, creation, people in relationships, and experiences are cyclical; everything moves in a circular fashion rather than linearly (Gustafson, 1997). This circular system represents balance, movement, return, change, and transformation (Arbogast, 1995; Gustafson, 1997), which are concepts that may resonate with transformational

qualities of art therapy (Campbell, Liebman, Brooks, Jones, & Ward, 2007; Scheitzer, 1997). McNiff (2004) reflected on this connection, writing that

> The artist and the shaman go to the heart of the inner storm and enact its furies in a way that benefits the individual and the community. The end result is not just emotional catharsis but deepened insight into the nature of human emotion. (p. 187)

McNiff (1992) discussed art therapy in comparison with shamanism as connected to personally sacred, personally important psychological experience. That is, as an intercultural therapeutic modality, art therapy may tap into personally sacred psychological experience, which is expressed in a particularly circular event of response—moving back and forth between the artist and the art, the viewer and the viewed. Art making may help some clients find the sacred personal that I, as their therapist, may not be able to see or understand, especially when working cross-culturally. McNiff proposed that patterns of personal, sacred knowing emerge when clients work therapeutically in all the arts. I think that this idea may also be reflected Allen's (1995) thoughts about how patterns of knowing, such as the identifying of patterns and themes in art to identify emotions and the choosing of specific art materials to express emotion in creating art, may express the personal sacred within clients.

Within many indigenous cultures, all aspects of life are seen as connected to each other in a web of infinite relationships (Badhand, 2002). No part of life is separate from another part. All animal species, all vegetation and mineral life, are related to each other and to the earth, so that nothing and no one can be understood outside of their place within this larger web of relationships. It is not possible to understand one person, or one event, by itself (Vecsey, 1992). Any discomposure of the circle of the four aspects of body, spirit, mind, and heart, often found in

the concept of the medicine wheel, causes ill health that may manifest in various ways (Bad Hand, 2002).

The Medicine Wheel. Native American tribal communities have used and interpreted the medicine wheel as a tool of healing and as a symbol of power (Twigg & Hengen, 2009). Representing a theory of how things work, the circle of the medicine wheel is considered a unifying symbol of everything, wherein an individual is incorporated in the circle and the individual's heart that is at the center. The sacred circle is often bisected into four areas that represent the four directions on the earth; the center is where the sky and lower earth connect at the heart. This schema represents how the individual connects to everything else in the world, and the universe within a web (Dapice, 2006). There are usually four colors attributed to the medicine wheel, (red, yellow, black, and white); where the colors are placed on the wheel varies depending on their interpretation by various Native peoples.

Known by Jungian scholars as a universal symbol of wholeness or mandala (Jung, 1968), the medicine wheel is considered the universal symbol for "everything" while it embraces change (Dapice, 2006). The balance, relationships, and holistic view of the world that exemplify the medicine wheel are an important part of many Native Americans' view of the world (McCormick, 1996). For many Native Americans, a balance of the four areas of the medicine wheel in all aspects of their lives represents health (Chansonneuve, 2007). Passed from one generation to another, the medicine wheel teachings, called "the way of the circle," are expressed through individual tribal customs and traditions (Garrett, 1999).

Native Healing Traditions. Traditions of healing within Native American communities have been used since before recorded history (Portman & Garrett, 2006). Using native plants and herbs throughout history, Native Americans have developed a rich and thriving therapeutic

tradition that coincides both in the past and present with one's individual community and native flora contexts (Mancini, 2004a, 2004b). Chee (1991) wrote that in the modern era, these healing traditions have most often been thought to be a system of holistic therapy offered by Native American traditional practitioners of medicine. Often referred to as medicine men or medicine women, shamans or herbalists, they use traditional indigenous herbs and ceremonies to effect healing, which may incorporate dance, chanting, singing, prayers, and sand painting in their therapeutic practice. Herbs may be given as smoke or imbibed as tea or in food (Chee, 1991).

Healing in many Native American cultures may be seen as a way of transforming life narratives, as Native American healing is much like telling a story (McCabe, 2008; Mehl-Madrona, 1997, 2005, 2007). Accordingly, experiences are considered narrative and they are connected to one's inner dialog within the mind, body, and emotions, as well as spirit. This dialogue is what brings together the client and the healer therapist. McCabe (2008) discussed the inner dialogue as being supported by the sharing of narrative; this, in turn, allows integration of emotions and thoughts, healing trauma. He likened it to an act of creation.

Stories and Art as Therapeutic Modalities

Stories and myths hold clues about how people respond to the many challenges that they face in life. They are meant to open our hearts and minds to multiple ways of dealing with life's circumstances. Stories can help us bring out the qualities we want in ourselves, such as strength, courage, and compassion, which are all aspects of the spiritual warrior. Because stories are an art form, each person who hears or reads a story will respond to it in their own unique way (Allen, 1995; Carlson, 1997; Durran, 2006; Elliot, 2003; Mehl-Madrona 1997, 2007).

One way that ancient wisdom is passed on is through the sharing of myths, stories, legends, and prophesies. Stories give us a place where we can find our life's purpose. They talk to our hearts, open our minds, and motivate us to act. Story is a way to connect with our soul and with others (Mehl-Madrona, 1997). Within my relationships with Native American clients, I have observed that there is recognition that such thinking is culturally based; that story is often based in culture, time, and place. The personal and culturally based understandings of story and myth are important ways in which people think and know (Wilson, 2008). Therefore, by understanding the importance of the relational quality of knowledge and knowing, we may come to recognize that all knowledge may be based in culture (Wilson, 2008).

The combination of stories and making art have always been a special way for people to communicate with and relate to one another. Practiced together, they also help people learn a great deal about themselves, the world around them, and the beliefs and values of their own and others' cultures. Stories delight and entertain while they also build a feeling of togetherness and group belonging (Mehl-Madrona, 1997).

Mehl-Madrona (1997, 2007), a researcher who has Lakota and Cherokee heritage, has been a strong proponent of storytelling as a therapeutic modality within Native American communities. He wrote that traditional culturally-based stories should be told to Native American children to help them connect to their cultural history and to develop a cultural identity. He proposed that Native Americans should be given such tools, such as internal images from culturally relevant story, to enable them to express themselves through art-making using culturally relevant and personally meaningful imagery.

The stories I tell in my office that are connected with art as art therapy do all of the above. Drawing on the rich, oral traditions of Native American people, and specifically Potawatomi heritage (Geniusz & Geniusz, 2009), I find that stories and art-making presented for

a therapeutic purpose can help express cultural heritage and basic human values like kindness, generosity, courage, and love. The traditional Potawatomi and Ojibwa tales are stories that touch themes universal to all peoples. They are stories about ordinary people meeting extraordinary challenges, as well as stories of spirits, of living in harmony with others, and about dreams that may or may not come true.

Traditionally, narrative in art therapy has been discussed as a discrete component of the process, often described as reimagining or re-authoring an event or memory. McNiff (2004) described this concept as "art telling a story to the artist" (p. 22). However, in my study there was an extra component: that of the story telling the art to the artist and then the artist returning the favor. In my work, artists use story as the jumping-off-place in the therapeutic process. Beginning with story, art describes aspects of receiving the story, such as intercourse with the storyteller, new cultural understanding, connections with personal story and history, or an understanding of current circumstances. The art becomes the story, as McNiff described, but it is informed by story as well. The story becomes historical, and intergenerational if you will, and therefore no longer lies within the ahistorical context of the isolated individual. Within my research, story and art combined to meet with traditional trauma on a community-wide scale, which allowed re-envisioning of the circular nature of traumatic events and traditional healing to meet individual and community needs.

In writing about how the development of story can be an extension of art making, McNiff (1981) defined narrative as an ongoing dialogue with others and a way of connecting with them. He wrote that creating narratives from art seemed to directly influence the clients' ability to access their feelings, asserting that "herein seems to lie the power and importance of language in the arts and therapy, in communicating a number of different, though related, thoughts that cannot be

expressed through other modes" (p. 90). White (2004b) described his own process of narrative therapy as a deconstruction and reconstruction of narrative. He explained that deconstruction ushers the client into "the adventure" (p. 155) and that the reconstruction helps the client to engage with that adventure. Glazer and Markham (2003) described the use of storytelling combined with responses to it in art when treating children who have experienced trauma. They concluded that both the art making and story combined to create more effective trauma intervention than each offered alone. McNiff (2004) considered that the need to define and name images may be what drives people to express themselves through story when talking about their art. He explained that fantasy and projection within the imagined dialogue between image and narrative helps to bring forth creative hidden thoughts and feelings as well as clarifying trauma.

Mehl-Madrona (2007), a researcher who has Lakota and Cherokee heritage, proposed the telling of culturally relevant stories to Native Americans as a therapeutic approach, which seems similar to McNiff's (2004) thoughts about the efficacy of story when imaginatively combined with art. McNiff asked, "Do the expressions of visual and kinetic images lend themselves to description by verbal narratives?" (p. 70). In response, he wrote that "images generate stories, imaginal dialogue and other forms of artistic expression, but they also act directly on our bodies, minds, and senses" (p. 72). McNiff was looking at how story emerges from art, whereas Mehl-Madrona was considering how story might inform art. Both seem to arrive at the same therapeutic conclusion: story and art making can reach a therapeutic conclusion together with more efficacy than each alone might achieve.

Often, when I tell a therapeutic story in my practice, the telling produces images that serve as illustrations of the story. Without knowing why clients chose a particular part of the story to illustrate, we embark in the therapeutic session on an investigation of what that particular part of the story means to the client. Described within the metaphor of image, the story line is re-

imagined as a new story. Even illustrations of stories may serve a therapeutic service, as either a lead-in to art making or a result of art making. Riley (2006) explained that the metaphor found within narrative and art therapy is the basic center of self-understanding and personal dialogue. She explained that the metaphor of art makes sense of an interior dialogue, and this can be therapeutic. When creating an image to accompany the narrative, the sense-making of the metaphor is sharpened as well as postponed, which might make the metaphor more readable to the client as the heart of the matter. Riley stressed that the meaning should not be the end result but rather the journey towards understanding. McNiff (1991, 2004) expressed this eloquently when he wrote about treating images as persons and dialoguing with them, and thereby creating a narrative that reflects the image and a story that emerges from the image. He wrote, "I consider the ethical consequences of how we treat images, suggesting that we give artistic expressions their autonomy, see them as distinct from ourselves, and learn how to relate to them in more imaginative and therapeutic ways" (2004, p. 71).

Riley (2006) described narrative art therapy as providing a frame for the therapeutic work and a context for the lived experience. She explained that "a story (narrative) can be defined as a unit of meaning that provides a frame for lived experience" (p. 97). The emphasis of therapy then becomes a "re-authoring" of the story through art and narrative, with a therapeutic goal of creating new endings to the story (O'Hanlon & Wiener-Davis, 1988, as cited in Riley, 2006). White and Epston (1990) wrote that re-authoring deeply involves a client in the therapeutic experience and suggests to them that the problems they are grappling with are external and not personal failings. Hoffman (1993) concurred, writing,

> I began to take more seriously the use of what I call "associative forms." If one is trying to break loose from a problem-solving approach the content of the interview becomes different as

> well as the style. The reason for using metaphor is not because they help you to insert suggestions into the unconscious of a client, but because metaphor hardly ever implies that people are doing something wrong. Advice or problem solving almost always does. (pp. 133–114)

Allen (1995) described patterns of knowing as applicable to narrative art therapy. She explained that her artistic images were "moved along" by her inner story (p. 78). Although Allen described her journey as an image journey, it was driven by her personal inner narrative. She wrote and illustrated the narrative of a personal journey in her text on the subject, noting that they would not seem complete had either the written narrative or illustrated narrative been left out. Allen's thinking suggests the influence of Eliade (2004), a Romanian anthropologist who researched traditional societies and their links to the sacred and imaginative value of art and narrative. He considered therapeutic stories as origin myths, writing that "myth, then, is always an account of a creation" (p. 92). He found that in many traditional societies the power of a thing lies in its origin; thus, if origin is the equivalent of power, then the first manifestation of a created thing is most significant and valid. Eliade considered myth to be sacred story that may be expressed through art or action.

Eliade (2004) identified traditional shamanic ways of healing that relate to making art. McNiff (1992) correlated such healing practices, as in focusing on experience more than concepts, with art therapy practices. He contemplated the idea of the shaman that can be found by healing within; in contrast, Eliade identified art-based and shamanic construction of inner reality. In his investigations of Indigenous uses of dreams, art, and other expressive modalities such as dance, music, and narrative, Eliade's (2004) reported sacred healing technologies of soul retrieval, shamanic drama, and masque. McNiff (1992) suggested that there are commonalities

with art therapy regarding thought, feelings, and expression. This connection closely reflects what Eliade described and how Native American healing is perceived to work. Both McNiff and Eliade expressed the belief that Eurocentric ways of expressing personal identity by what people do rather than what they feel may obfuscate the necessary oneness of identities and dampen the human creative spark. In pointing out the commonalities of cultures within the realms of imagination, comparative myth, and creativity, McNiff (1992) did not hold that all cultures are the same. Rather, he asserted their common impulse of creativity and spiritual expression, as did Eliade (2004) and Dissanayake (1995).

Art therapy that uses culturally significant stories may tap into a sacred psychological experience. McNiff (1992) suggested that patterns of personal, sacred knowing emerge when clients work therapeutically in the arts. Allen (1995) identified patterns of knowing applied to narrative art therapy also might express the personal sacred within clients.

Native American Knowledge Creation

Dufrene (who identifies as Powhatan-Renape Native American) and Coleman (1994) are two of few authors in the art therapy literature who discuss how Native American populations can best be served through art therapy. They reminded art therapists that contemporary U.S. Native Americans are a product of both the dominant and the indigenous North American cultures. They noted that some archetypes are culturally specific and that therapy should be culturally specific to the clients served. Herring (1997), a counselor who works with Native American clients, identified specific professional and ethical issues that should be addressed, such as asking about their spiritual beliefs and how they might impact the therapeutic

process. He further posited that the creative arts and Native American spiritual values might interconnect in order to work therapeutically with a Native American population.

There is a history of work by non-Native American researchers that has described and theorized about Native Americans, often without allowing Native American participants to express knowledge from their own perspective. Ladd (as cited in Smith, 2012) wrote of the difference between Native American and Western European knowledge systems:

> [They each] contain their own unspoken rules as to what can or cannot be said and how, when and where. Each therefore, constructs cannons of truth around whatever its participants decide is admissible evidence, a process that in the case of certain prestigious discourses, such as those found in universities, medical establishments and communication media, can be seen as particularly dangerous when unexamined, for these then come to determine what counts as knowledge. (p. 76)

Important when conducting research with Native Americans is an understanding that each community is unique in the micro-culture of experience, community, and practices (Davis & Reid, 1999; Habermas,1978), and that community members who are active as full partners in research help to produce accurate data and build community ownership of the results. For instance, research that is communal, participatory, and collaborative can address issues that are known and recognized by members of the community but may not be apparent to outside researchers. When conducted as an intentional form of decolonization, research that provides Native Americans the space to communicate from their cultural frame of reference becomes a strength-based system of addressing problems (Laeniu, 2000). Decolonization in this regard is defined as a process of rediscovering ancestral traditions and cultural values. Self-determination

within decolonization includes legitimacy of history, story, myth, ways of seeing reality, and ethics.

With respect to therapy practices, it is important for a therapist to determine what the client wants and needs, given that their needs relate to their culture and identity when working inter-culturally (Sue, Allen, & Conway, 1978; Trimble & Flemming, 1989). Referred to as culturally sensitive practices (Moody, 1995; Morrisette & Gadbois, 2008), therapists who work with Native Americans often use local traditions specific to a particular tribe to adapt their practice to meet cultural needs of their clients (Battiste, 2008; Gerrity, 2000; Herring, 1997).

Ybak (2009) and Decker-Fitts (2009) described some basic values and views of some therapists who work cross-culturally with Native Americans. Concepts believed to have value as therapeutic modalities are the use of the medicine wheel, dance and smudging, sweat lodges, herbs, and pipe ceremonies, as well as culturally specific storytelling. Both Ybak and Decker-Fitz concluded that knowledge of Native American culture is key in counseling Native Americans.

However, there has been little research to measure what, if any, effectiveness may be gained by mixing Western European psychological approaches in therapy with a Native American cultural overlay (Gray & WanmidiWi, 2012). In my own work, I have observed that offering therapy within a framework of a self-guided, culturally-based practice seems to be effective (Warren, 2015a, 2015b). For my research study, I proposed that combining art therapy techniques with community-specific Native American cultural practices may be effective in reducing intergenerational trauma and developing an appropriate assessment tool to meet community needs.

The Research Project

Problem and Rationale for the Study

According to their own report, members of the Forest County Potawatomi community are not regularly exposed to the traditional cultural oral stories told in earlier generations. This absence may be due to intergenerational trauma that has reduced the intergenerational telling and learning of traditional stories, resulting that some cultural history has not been passed down to new generations (Adams, 1995; Mehl-Madrona, 2007). I have observed in my practice that Potawatomi clients suffering from grief and loss have difficulty expressing themselves through art making within art therapy, possibly due to cultural constraints that restrain emotional expression in ways that do not reflect their cultural heritage. I believe that this outcome can be detrimental in art therapy, especially when clients do not have ready personal access to culturally specific beliefs, images, history, art processes, and stories. My proposal was that if a connection to their Potawatomi culture is provided through myth and story, then treatment for grief and loss may more likely be expressed in their art making (Glazer & Marcum, 2003). This hypothesis is supported by Mehl-Madrona (2007), who asserted grief and loss from intergenerational trauma may be more easily treated if Native American clients are able to access culturally traditional stories, myths, and internal images (Mehl-Madrona, 2007).

Archetypal forces depend upon the physical forms of the arts in order to manifest themselves in the world, and the arts similarly need the agent of imagination to manifest (Jung, 2009; Mehl-Madrona, 2007). Carlson (1997) examined how art might be used to help the externalization process, which in turn may be an avenue for helping Native American children express themselves. He made an in-depth study of narrative therapy and its similarities with art

therapy, examining literature as part of his exploration of some basic premises of art therapy. A case study was used to illuminate Carlson's link between narrative therapy and art therapy as an enhancement in processing a story. He found that through art making expressed from a story, a new story emerged and the new story reframed the problem in a way that effected healing.

I wanted to study traditional Potawatomi stories combined with responses in art in order to meet the needs of the community and to increase the art therapy knowledge base. Because of the history of White intrusion into Native American cultures, in determining what is and what is not acceptable research I concluded that the Potawatomi community with whom I work should have direct input regarding the development and definition of any study's research design (Battiste, 2008; Smith, 1999). Minkler and Wallerstein (2003) wrote that participatory community-based research design, known as participatory action research (PAR), may be effective in meeting these autonomy needs of a Native American community within a research process, particularly with the community designs the research and determine the process, how data may be collected, and how the results will be used.

Participatory Action Research

PAR is a form of research aimed at a better and more local understanding of social phenomena (Booth, Colomb, & Williams, 2008). Based on what is going on within the actions of participants as they interact with each other, PAR is pragmatically focused on what is most useful to the participants (who are regarded as co-researchers) and the community (Bowman, 1991; Whyte, 1991). The National Congress of American Indians (2009) recommended culturally relevant research practices based on the collective wisdom of community elders, retention of story-telling as part of the research process, and practices that reflect cultural values.

Driven by community members as co-researchers, PAR embraces both Native American culturally-based ways of knowing and scientific understanding through an evidence-based

assessment (Cochrane, et al., 2008; Forster, et al., 2007). Because of its ability to reflect various cultural values, community-based PAR is now considered part of an informal code of conduct when conducting research within Native American communities (Rushing & Stephens, n. d.).

Procedures

I worked with community participants in a research project that (a) honored narrative and art therapy sensibilities concerning the roles of the therapist and client, and (b) was useful for examining the therapeutic qualities of narrative therapy practices within the Native American culture (Moody, 1995). In a series of workshops over the course of several months, I co-facilitated with Potawatomi community members their telling of a traditional Potawatomi story and participant responses to it in the creation of a traditional sculpture using wood, paint, and various tools. Attendance at the workshops ranged from 15 to 25 participants of various ages (from age 8 to 90). I worked with community members throughout the process of story choice, setting up the workshop, inviting participants, and creating the opportunity for the workshops to occur. Tribal and community members led the project as co-researchers throughout the research process.

The Workshop Experience. As detailed in subsequent chapters, three workshops surrounding the decolonization theme of the *snow snakes* traditional game (described below) were planned to span the winter months of November through early January. An Elder from White Earth, MN led the workshops, teaching how to make snow snakes, their history via story, and how to play the game. While he taught the game, the Elder also told a legend that contained cultural knowledge and wisdom.

Some community members attending the workshops had not heard the story told before. I asked younger participants of the workshop to draw their favorite part of each story, and a community member discussed the day's work with participants about their experience, using the

format of a talking circle, which is made up of a group of participants who sit in an inward facing circle (Wilson, 2008). A facilitator encouraged discussion regarding the experience of the workshop (Weiss, 1994). Sharing of the response artwork was encouraged with reflections about how the decolonization experience might reflect participant's own lives.

On the second day of the first two-day workshop, the Elder led the workshop participants into the woods to look for tree branches that could be turned into snow snakes, an object used in the game. Participants returned to the indoor workshop space, used tools to strip the bark from the branches, and heard the story again. They also could make another piece of art in response to the experience thus far. A talking circle on the subject of the day's activity was facilitated by a community member.

The second two-day workshop took place in late December, when the snow was deeper and more conducive to playing the game. The Elder from White Earth returned and began the workshop by telling the story again. The branches were decorated, using paint colors and motifs determined by participants to decorate their snow snakes in a way that represented their personal style. A talking circle was again facilitated by a community member.

The second day of this workshop saw the completion of decorated snow snakes. A playing course was created in the snow by community members, led by the Elder, and the game was played. A talking circle was facilitated by a community member at the day's end.

The third workshop was held a week after the second workshop and was facilitated by a community member who told the story of the snow snakes with the help of participants. Then the game was played using participants' snow snakes. As the art therapist, I offered a third opportunity to create art in response to the experience. Finally, a talking circle was facilitated by a community member to discuss the process of learning to play, and of playing the game.

The Snow Snake Game. Horwich (2014) wrote that the Snow Snake game is named for the artistically designed and decorated seven-foot poles that are thrown along a slippery ice trough that may be as long as a mile. According to Iroquois oral tradition, the Snow Snake game may date back more than 500 years. Originally a form of communication between communal villages, the throwing of snow snakes in a trough of snow developed into a competitive sport during the winter whenever the ice track was not used for communication (Parker 1909). The name "Snow Snake" comes from the wiggling motion of the poles as they slide down the icy track (Indian Country Today Media Network Staff [ICTMNS], 2012).

Snow Snakes are carved from hickory, maple, or birch branches with great care in sculpting. Carved by hand, the branches are smoothed down to an inch or less in diameter and fitted with a lead tip to weight them for more control (Parker 1909). Most players decorate them with culturally significant, colorful designs (ICTMNS, 2012).

Teams traditionally have four players, who throw the snow snake down a hollowed-out trough about five inches deep in an icy platform raised above the snowpack. To create the trough, team members balance on a log while others pull it along the raised snow, digging a pathway through the platform (Parker, 1909).

Consistent with PAR, my role as a researcher was to observe the process, make meaning of my observations in collaboration with community members, and then take action by testing the research questions and co-determining results with the community participants. Ongoing data analysis included observation and feedback from co-researchers and their working hypotheses regarding the data. Their participation was particularly important because I am not a member of the community. The specifically Potawatomi cultural view was crucial to obtaining a clear and accurate assessment of the data.

Data Gathering and Analysis

I worked with co-researchers to develop the process/workshop, and to describe how one action over another was chosen, as part of data analysis (Creswell, 2007; Leavy 2009). I revisited the data set often and attempted to make meaning from the entire observational process in order to discover how the process informed the over-arching research questions (Alvesson & Karreman, 2011; Creswell, 2007; Denzin & Lincoln, 2013; Leavy, 2009). I also did ongoing journaling throughout the process, not only to record my observations but also to record ongoing meaning-making, ideas, thoughts about the research method, theoretical considerations, and personal questions that arose from the observations. I reflected on this process and then shared my reflections with members of the community whose input provided alternative interpretations (Emerson, Fretz, & Shaw, 2011). I directly observed all parts of the research process and worked to make meaning of my observations in collaboration with community members. I shared my thoughts and own artwork created in response to my experiences with co-researchers and received their responses to my meaning-making. I tested the research questions against my meaning-making and the responses of my co-researchers/participants. This ongoing data analysis involved continuous feedback to and from participants, and included observations and updated working hypotheses regarding the data.

Conventional data coding is not recommended for research with Native Americans (Chilisa, 2012; Solomon, Randall, 2014; Wilson, 2008). However, I found that the talking circles used to debrief after each workshop day gave insight into the processes that had occurred. Themes that arose in the talking circles included: a) what constitutes racial identity, b) how racial identity is constructed, c) resistance to and/or embracing of cultural identity, and d) transformation that may have occurred during the workshop experience.

Significance of Study

Very little has been studied about providing art as therapy within Native American settings. Though many Native American communities value art highly (Benton-Banai, 1988; Wilson, 2008), most therapy offered to them is verbal, traditional therapy. Moreover, literature on the subject of art therapy work with Native Americans is sparse. Therefore, research findings that advance knowledge of cross-cultural art therapy work in Native American communities is needed and significant to the field.

Permissions

The study was approved by the Institutional Review Board of Mount Mary University. I required a consent form (Appendix A) to be signed by all participants, and in the case of children participating, parents or guardians signed the consent form. The Forest County Potawatomi Clinic Health Board, which is made up of tribal members, was petitioned for permission to conduct my research and they gave written permission. Participants were notified of their rights and protections.

Specifically, participants were notified of:

- Purpose: The study was to better understand a traditional Potawatomi view of decolonization and the use of art as a part of the workshops.
- Procedures: Interviews were conducted to gather information relevant to a traditional Potawatomi view of decolonization using art. The notes were transcribed and articles were written to complete the research process.
- Duration: An understanding of the expected length of participation.
- Risks: An understanding of the risks associated with participation in this study, which included possible feelings of discomfort answering some questions that were raised in the talking circles.

- Benefits: An understanding of the benefits associated with participation, including that the study might have no direct benefits. However, participation in this study also had potential to increase participants' understanding of this topic.
- Confidentiality: An understanding that all information participants revealed in the study would be kept confidential, unless express permission to disclose was given in writing. Participant interviews were identified only by number and classification during the assessment process. All data was kept in a locked file and later destroyed. It was not anticipated that data from this project would be used in future studies.
- Voluntary Nature of Participation: An understanding that participating in this study was completely voluntary and that participants were allowed to withdraw from the study and stop participating at any time without penalty or loss of benefits to which they were otherwise entitled. Participants simply needed to state to the researcher that they no longer wished to participate. In addition, participants were allowed to withdraw all of their data from the project. If participants did not request the withdrawal of data, it was used as part of the project, it was kept and later destroyed along with all other project data.

Research Findings

As described in subsequent chapters, the co-researchers sought to discover whether members' investment in participatory art and narrative processes would raise self-esteem for the collective and affect participants' self-perception, personal belief system, and their perceptions of their culture. The results of the participatory action research project suggested that the workshops were indeed experienced as positive for the participants. We found evidence of the following outcomes: (a) community ownership of the process of inquiry; (b) recognition of the spiritual nature of traditional story, art, and game playing; (c) insights from reflecting on the art made and the art-making process; and (d) knowledge drawn from traditional practices.

Community Ownership of the Process. The entire PAR project was impacted by the community's ownership of the inquiry. The core group comprised of tribal leaders, members, and elders invited my participation in the role of art therapist; they developed culturally appropriate methodology and framed the research questions. Thus, the community had a significant investment in the project and used the project to create community ownership of traditional values. For example, the interest of the elders in rebuilding the knowledge of the Snow Snake game was not anticipated by the core group of co-researchers. The elders' strong participation and interest in the inquiry process helped build interest in younger community members for learning the traditional game. Comments from adult participants included, "I will have to practice this and show my old Aunty that I'm as good as her father was," indicated the importance of elder participation.

Recognition of the Spiritual Nature of Traditional Arts. The workshop series was designed to teach a traditional story and game, which the participants found enjoyable for building relationships across generations. Another, less expected outcome was the community's recognition of the spiritual nature of the experience that grew over the course of the research

process. For example, the core group did not anticipate resistance by participants to audio or video recording the workshops on spiritual grounds. From what participants learned about the spiritual nature of the process prior to the workshops, they determined that they would only participate if no recording equipment was used. Participants reported a sense of higher self-esteem after having their wishes acknowledged and met. As an example of spiritual insight, one participant walked directly toward a branch as her choice as the basis for her snow snake, then turned and reported that she had experienced a dream vision of the branch the night before.

Insights into Health and Wellness. Workshop participants noted their enjoyment of outdoor activities included in the workshop experience. Some described the joy of entering the snowy woods to find just the right branch for their snow snake. The experience of creating the throwing track and playing the game was tiring and required strength as well as skill. Several participants mentioned that they would continue to practice their throwing technique by "building my throwing arm."

Knowledge of Traditional Practices. Learning about traditional practices was an important aspect of the project for community members. This knowledge ties the PAR experience together holistically as a reference for education and self-esteem, personal and community determination, personal choices, and coping skills. Comments noted during the workshops such as, "see, Dad, I can make this and show it at school! And, I'm going to tell the story that goes with it," and, "I need to draw out my thoughts about the snow snake design," point to multiple domains of growth from the workshops.

Some participants described their experience in the workshop as "life changing" in terms of their interest in learning more about the Potawatomi's early culture and tradition. They said that they made beadwork to commemorate their newfound knowledge, as a way to honor a new understanding of life. From the assessment process, they found that, rather than

compartmentalizing their experience into the four medicine wheel areas (described below), they may have been looking for the wholeness that comes from the four quarters becoming balanced.

Secondary Results: Medicine Wheel Assessment

To assess outcomes of the snow snake workshops, part of the process was to build an evidence-based assessment tool that community members felt comfortable using. A core group of co-researchers sought to discover whether community members' investment in the participatory, communicative, and art-making process of the project could be used to collectively build a culturally relevant assessment for future healthcare interventions.

The assessment-building process was an outgrowth of the workshop research and was organized around a subsequent series of talking circles for a group of adult community members. The co-researchers were comprised of (a) the core group, which functioned as a collaborative research team with representatives from tribal leaders, elders, and the community, along with myself; and (b) focus group (i.e., talking circles) members, who helped select culturally appropriate assessment methods and met to evaluate the assessment instrument goals.

All researchers and participants were well-known and respected partners in the community. I identified community members from my outreach work, which provided a base from which to build the co-researcher relationship. I began the process of creating the assessment-building team with a visit to a prominent elder in the community, who was helpful in directing me to other elders who provided background and context for the proposed project.

Participants in the assessment-building process were recruited from community-wide invitations via individual contact. A series of twice weekly talking circles were planned to number a total of eight over 4 weeks. At least six members of the core research team, including one elder, were present at each talking circle. Participants could attend if they were at least 18 years old, and

there was no upper limit on participant age. The talking circles were held in the community recreation center.

The talking circles were recorded through hand-written note taking. Each talking circle began and ended with a sage smudging. Talking circles lasted 2 hours, with the first hour for the talking circle and the second hour set aside for reflective art making. We agreed that after a recap of the last talking circle discussion to set the agenda for further discussion, the talking circles discussion would be unguided, and that the reflective art made belonged to participants and would not be a part of the data collection. The talking circles were facilitated by two members of the core group known by all participants. Participants agreed that the goal of the talking circles was community involvement and ownership of care, and for positive-outcome assessment-building input.

Two co-researchers (one community member and myself as a noncommunity member) wrote notes during and after the talking circles and debriefed with one another after the circles had closed. We discussed themes in the conversations, what we observed of body language and how it might be interpreted through a cultural lens, and made notes for assessment later.

During the 4-week assessment, I met with the assessment tool-building core group on a weekly basis to discuss what and how they wanted to learn from the knowledge created by the community talking circle, according to our pre-established goals of developing a specific research boundary (Montour, 2000) that structured questions in accordance with the assessment tool used with art making. We spent one hour of the 2-hour meetings reflecting on the process through art making.

As the basis for the assessment, we decided upon four subjects aligned with the four areas of the medicine wheel to guide clients in helping in the art therapy assessment process and build

avenues for further discussion (Cochrane, Marshall, Garcia-Downing, Kendall, Cook, McCubbin, & Grover, 2008). Outcomes from the talking circles were grouped according to the four parts of the medicine wheel to build the assessment tool. Co-researchers worked together to agree on where within the four domains of the medicine wheel the data sets should fall as contributors to the final process (Arambula & Randall, 2014). A final step took the data analysis to the elders who had contributed information to the process for their input into our conclusions.

The results suggest that the talking circles with personal art making were helpful in creating the assessment tool and positive for the participants. We found evidence of the following outcomes: (a) community ownership of the process of inquiry; (b) an evidence-based culturally relevant art assessment tool created through community participation; and (c) insight from reflecting on conversation and the art offered insight into cultural and experiential world views.

Community Ownership of the Process. The entire PAR project was impacted by community ownership of the inquiry. The core group (comprised of tribal members, elders, and community members) invited my participation as an art therapist, developed culturally appropriate methodology, and framed the research questions. Thus, the community had a significant investment in the project and used the project to create community ownership of traditional values. The talking circles were suggested by the core group as a way to honor the culture, build investment in the process and outcome, and to build a positive-outcome based assessment tool (Barkham & Mellor-Clark, 2003).

Evidence-based Assessment Tool for Art Therapy. A checklist for use by therapists regarding the medicine wheel as a basis for assessment of art therapy sessions was produced

through discussion in talking circles that was coded and analyzed by co-researchers. Researchers created the checklist to address issues brought up in the talking circles, including such physical aspects as how art media is used and the care taken of completed art. Cognitive aspects include assessment of engagement in the art process; emotional aspects include affect during art making; and spiritual aspects include expressions of spiritual beliefs through art (Brooke, 2004).

Two self-assessment tools were created: one to be placed in the community clinic's client chart and another for clients to take home. These tools were planned to include clients in the assessment process, allowing them to interject their viewpoint into the process, and thus giving them ownership of their care.

Cultural and Experiential World Views. Being able to express traditional beliefs and practices within the therapeutic environment was an important aspect of the entire project for community members. The ability to produce a viable assessment tool tied the PAR experience together holistically as a reference for education and self-esteem, personal and community determination, personal choices, and coping skills. Creating a checklist for professional use, and comprehensive self-assessment tools that meets community needs, points to multiple domains of growth from the talking circles (Lee & Armstrong, 1995). When creating the assessment tool, participants noted their experience in the PAR process as "empowering" in terms of their ability to direct their own care. Rather than compartmentalizing the assessment effect within the four medicine wheel areas, community members reported seeing the wholeness that comes from the four quarters when they are in balance.

The core group and I worked through the data and collaborative discussion, from which we developed medicine wheel-based worksheets to be used by both a therapist and client in conjunction with the assessment guide checklist. The talking circles and the medicine wheel structure were determined to be an appropriates methodology to gain

participants' subjective perspectives (Rodwell, 1998; Wilson, 2008). The medicine wheel evaluations were created for clients to participate with equality of power in influencing care decisions.

Conclusion

Informed by community collaboration, a collaborative community-driven research project was built that combined art therapy with narrative therapy to meet the specific cultural needs of Native American research with the aim of a transformative outcome. The study was developed to build personal and community healing in the context of a long history of colonization. The specific cultural practices of a Potawatomi community were researched with community members who participated in the research process from beginning to end. The goal of the research project was not only to collect and disseminate information, but also to create a greater sense of self-esteem and an embrace of the research community's culture.

The following chapters present the research project and its findings in the form of three publication-style manuscripts, which in an article-style dissertation must relate to each other thematically and each present an original and unique contribution. Each chapter, accordingly, begins with the article's abstract, followed by an introduction, review of literature, methods, and findings.

CHAPTER TWO:
SNOW SNAKES: AN ART THERAPY DECOLONIZATION PROJECT WITH A NATIVE AMERICAN COMMUNITY

Abstract

This article describes arts-based participatory action research in partnership with a Native American tribal community. Art therapy was combined with narrative therapy to meet the specific cultural needs of a community's art-based research, achieving a transformative outcome. The study sought to rebuild a traditional cultural connection within a Potawatomi Native American community in such a way that would support personal and communal healing. A connection to their specific Native culture was provided through communal participation in a series of workshops that utilized myth, story, and art. These elements reflected their cultural traditions and created a greater sense of self-esteem and an embrace of their culture. Community-based art therapy in participatory action research strengthened the spiritual, personal, and social development of the co-researchers and made a difference within the community.

Introduction

Few cultures within North America have endured such a sustained assault on their rights, culture, and lives, as have Native Americans (Chansonneuve, 2005; Fournier & Crey, 1997). When viewed from the perspective of Native Americans, the onslaught of genocide that accompanied the European settlement of the New World must have felt like an "unrelenting destruction on a massive scale" (Chansonneuve, 2005, p. 6). Before European contact, an estimated seven million or more Native Americans resided in North America (Chansonneauve, 2005). Within a few years of conquest, more than 90% of this population was dead; many from smallpox, measles, and influenza, war, theft of property that caused displacement, poverty, and starvation (Chansonneauve, 2005, Duran & Duran, 1995). However, it is only within the last 20 years that the intergenerational nature of such trauma has been examined within Native American communities and from their own perspectives (Adams, 1995; Braveheart-Jordan & De Bruyn, 1995; Lederman, 1999; Waldram, 1997, 2004).

In the United States, the most recent of 300 years of ongoing trauma and loss demanded assimilation into the prevailing culture through forced attendance at government sponsored boarding schools (Adams, 1995; Chansonneuve, 2005; Cohen, 2003; Hodgson, 1990; Olson & Wilson, 2008; Witko, 2006). Gagne (1998) and Hodgson (1990) identified the colonization experience of residential school in the late 19th through mid-20th centuries as a key component of the intergenerational trauma experienced by Native Americans. These thoroughly colonized people were then returned to their communities as adults, no longer knowing their tribal or community

language, customs, or their cultural heritage (Chansonneuve, 2005; Cohen, 2003, Olson & Wilson, 1986; Witko, 2006). The rupture between generations was devastating; it contributed to decades of unresolved grief, shame, anger, and endemic struggles with behavioral, emotional, psychological, and spiritual issues that continue to impede wellbeing.

McNiff (2009) and other art therapists have discussed the importance of developing a culturally sensitive practice, but little has been written about this population and its needs. In their discussion of how the profession can best serve Native American populations, Dufrene (who identifies as Powhatan-Renape Native American) and Coleman (1994) reminded art therapists that contemporary Native Americans are a product of both the dominant and indigenous North American cultures. In my own work, clients and I discuss the trajectory of therapy in light of culture and the cultural philosophy they want to emphasize in the therapeutic process. However, the clinic's model is based upon U.S. medical care that most often is provided by practitioners who know little about the cultural traditions of the community.

I work cross-culturally as a White art therapist within a Native American community mental health facility in northern Wisconsin. The clinic offers outpatient mental health care. In my practice, I must consider the impact an art-based intervention might have in light of possible continuing colonization. This self-reflexive questioning of intent and imposition has been constant. As I have gradually strengthened my relationships with the leaders of the tribal community, I have learned from them that their members are not regularly exposed to the traditional stories told in earlier generations. Other cultural information also has been lost, including traditional games (Adams, 1995). The current study sought to rebuild the connection within the community in such a way that would support personal and communal healing. I posited that a connection to their specific Native American culture, provided through

story and art therapy, would move participants toward an embrace of their culture, resulting in a greater sense of communal- and self-esteem.

Literature Review

Intergenerational Trauma and Why History Matters

Trauma has been examined in many discourses throughout the research literature. The transmission of trauma has been explained as an event experienced by one person that has lingering effects on others (Lev-Weisel, 2007). When an individual who has experienced a trauma is faced with another overwhelming, threatening, or uncontrolled situation, the brain's central nervous system revisits the initial trauma and, over time, becomes reactive and unable to cope (van der Kolk, 1987), which suggests that coping and adaptation patterns, both conscious and unconscious, can be changed and passed down to future generations. As an example, Kellerman (2001) noted that as children learn from their parents, a bridge is created between the original trauma and future generations; children observe their parents' behavior that was based on their traumatic experience and take on that behavior. Thus, the pain of the trauma borne by many members of Native American communities appears to have impacted not only the direct trauma of survivors but the following generations as well.

Root (1992) called these experiences "insidious trauma" (p. 1) because subsequent generations are often unaware of how their current experiences originate from their community's losses. The community becomes inured to the oppression, which leads to the view that the world is unsafe for everyone (Kirmayer, Brass, & Tate, 2000). Large-scale ethnographic studies have suggested that descendants of trauma survivors may impact children's acquisition of their Native cultural values, beliefs, practices, and language (Rodriguez & Sanchez Korrol, 1996; Suarez-Orozco & Suárez-Orozco, 2001). As Kirmayer, Brass and Tait (2000) wrote:

> The emphasis on narrating personal trauma in contemporary psychotherapy is problematic because many forms of violence . . . are structural or implicit and so may remain hidden in individual accounts. Individual events are part of larger historical formations that have profound effects for both individuals and communities. (p. 616)

The hidden nature of historical and current Native American trauma includes aspects of continuing colonization policy within the U.S. government, debilitating poverty due to reduced economic opportunities, and lack of basic civil rights such as attending school, voting, and identifying as Native Americans. For instance, the Wounded Knee Occupation in 1973 by members of the Oglala Lakota highlighted the U.S. government's history of not honoring treaties and the grinding poverty of reservation life (Sayer, 1997). The U.S. Racial Integrity Act of 1924 (not overturned until 1967) made it a crime to identify as Native American and Native Americans were not allowed to vote until 1927. These are some of the hidden traumas that continue to inform life for Native Americans.

Native Healing Traditions

The personal and culturally based understandings of story and myth are important ways in which indigenous people think and know (Wilson, 2008). Within Native American cultural traditions, life experiences are connected to a person's inner dialogue within the mind, body, emotions, and spirit. When such traditions are at the fore, the role of the healer in the community is to attend to the person's body, mind, and soul when they are ill. Communication with the spirit of the illness, and how the spirit might be changing the patient's inner dialogue, is an important part of returning to former health in body, spirit, emotion, and mind. Healers also use community stories to help sick individuals, often with ceremony and ritual to intercede with the spirit world by directly asking for help for the patient (Mehl-Madrona, 1998, 2003, 2005, 2006).

Art therapy may provide an opportunity for Native people to visually and metaphorically incorporate concepts of spiritualism and humanism that have traditionally been infused in all aspects of the Native American culture, including the creative arts (Coyhis, 2009). In many Native American communities, the creative arts represent avenues of emotional, religious, and artistic expression that remain an essential part of the lives of community members (White & Epston, 1990). Riley (2006) wrote that when art images are created to accompany narrative, the sense-making of metaphor is sharpened as well as postponed, making it more readable to the client as the heart of the matter. The emphasis of therapy then becomes a "re-authoring" of the story through art and narrative, thus creating new endings to the story.

Healing practices in Native American cultures may be seen as a means for transforming life narratives. When experiences are considered stories, they may be connected to one's inner dialogue within the mind, body, emotions, and spirit (McCabe, 2008; Mehl-Madrona, 1997, 1998, 2005, 2007). McCabe (2008) described the sharing of narrative as supportive to the process of integrating emotions and thoughts to heal trauma. In many Indigenous cultures, the building of personal identity includes a sequential master story that links together multiple present and past stories into a life story.

Mehl-Madrona's (2007) proposal of telling culturally relevant stories toNative Americans as a therapeutic approach seems similar to McNiff's (2004) thoughts about the efficacy of story when imaginatively combined with art. McNiff believed that "images generate stories, imaginal dialogue and other forms of artistic expression, but they also act directly on our bodies, minds, and senses" (p. 72). McNiff was looking at how story emerges from art, whereas Mehl-Madrona was looking at how story might inform art. However, both seem to arrive at the same therapeutic

conclusion: that story and art-making can reach a therapeutic conclusion together with more efficacy than each alone might achieve.

Native American Knowledge Creation

The work by non-Native American researchers in the past described and theorized about Native Americans, often without allowing Native American participants to express knowledge from their own perspective. Ladd (as cited in Smith, 2012) wrote of the difference between Native American and Western European knowledge systems:

> [They each] contain their own unspoken rules as to what can or cannot be said and how, when and where. Each therefore, constructs cannons of truth around whatever its participants decide is admissible evidence, a process that in the case of certain prestigious discourses, such as those found in universities, medical establishments and communication media, can be seen as particularly dangerous when unexamined, for these then come to determine what counts as knowledge. (p. 76)

Important when conducting research with Native Americans is an understanding that each community is unique in the micro-culture of experience, community, and practices (Davis & Reid, 1999; Habermas, 1978), and community members who are active as full partners in research help to produce accurate data and build community ownership of the results. For instance, research that is communal, participatory, and collaborative can address issues that are known and recognized by members of the community but may not be apparent to outside researchers. An intentional form of decolonization, when it allows Native Americans the space to communicate from their cultural frame of reference, research can become a strength-based system of addressing problems (Laeniu, 2000). Self-determination within decolonization includes legitimizing history, story, myth, ways of seeing reality, and ethics.

The current study gave me an opportunity to work with tribal community members to create a participatory "decolonization" project that would offer culturally specific art and narrative therapy for the purpose of creating knowledge within and by the Native American community. Together with tribal elders, I wanted to see how members' investment in participatory art and narrative processes might change self-perception and raise self-esteem (Kirmayer, Brass &Tait, 2000). Our guiding research question asked: How might traditional story and game, and art-based activities affect community participants' perceptions of their culture, their personal belief system, self-esteem, and change their self-perceptions?

Method

Participants: Co-researchers

The study was designed as a participatory action research project that was organized around a series of art and storytelling workshops offered through the tribal medical clinic and financially supported with a grant. Co-researchers (discussed below) were comprised of: (a) the core group, which functioned as a collaborative research team with representatives from tribal leaders, elders, and the community; (b) focus groups (referred to as talking circles), who helped to select culturally appropriate methods for the workshops and met to evaluate achievement of the study goals; (c) workshop facilitators; and (d) workshop participants, including children, youths, and young adults. All participants were informed of their rights and protections as co-researchers, and provided with details of the project's purposes, procedures, recording of data (which they could refuse), expected duration of participation, risks and benefits, and the voluntary nature of participation. All participants provided their written consent and, in the case of children participants, parents or guardians signed the consent. The research design was reviewed and

approved by the community clinic health board and the institutional review board of the Potawatomi community in which the study took place.

The research team was developed with representatives from community and its leadership. Tribal community members (which is language they use to identify themselves) had asked the clinic providers for more culturally relevant treatment for community members and, in particular, were seeking a way to reintegrate historically traditional culture into the community, as well as to engender pride in their tribal culture and to raise personal self-esteem. Consequently, I was invited to work with community members to design a community-wide experience that integrated traditional stories, art-making, and a traditional game into these community goals. Culturally appropriate methodology within a participatory model to deal with the research challenges of working inter-culturally was a key component in co-designing the study.

When co-researchers and participants trust each other, there is a greater motivation to participate in the research process. In this research project, trust was facilitated between all researchers and participants by well-respected partners in the community. In my case, from having worked with nearby Native American communities over several years, I had developed relationships within the project community that provided a base from which to build co-researcher and participant involvement. I began the process of creating the research team with a visit to a prominent elder in the community. He was helpful in directing me to other elders who provided background and history for the proposed project. The elders, in turn talked about the project within the community, thus stirring up interest in the younger members. Knowing the right people (i.e., grassroots leaders and people respected by others) was a key contributor to building attendance at the workshops.

Procedures

Snow snakes. The core group determined that we would offer three 2-day weekend workshops to reintroduce a traditional game called "Snow Snakes" that had been played by the Potawatomi in the past but was not currently a part of the community culture. Horwich (2014) wrote that the Snow Snake game is named after artistically decorated, seven-foot long poles, which are thrown along ice troughs that have been formed in the snow. According to an Iroquois oral tradition, the game may date back more than 500 years. Originally a form of communication between communal villages, people wrote messages on the snow snakes and threw along in a long trough of ice or snow that connected the communities. The game later developed into a competitive sport for whenever the troughs were not used for communication (Parker, 1909). To create the trough, team members balance on a log while other players pull the log along a raised snow platform, digging a pathway (Parker, 1909). Teams traditionally have four players who take turns throwing the snake down the hollowed-out trough.

The name "snow snake" comes from the wiggling motion of the poles as they slide down the track (*Indian Country Today* Media Network Staff [ICTMNS], 2012). The snow snakes are carved from hickory, maple, or birch branches, with great care taken in the sculpting and smoothing of the finished game piece. Carved by hand, the sticks are smoothed down to an inch or less in diameter and fitted with a lead tip to weight them for more control (Parker 1909). Most players decorate them with culturally significant colorful designs (ICTMNS, 2012).

Workshops. Participants were recruited from community-wide invitations via individual contact, mailings to tribal members, and posters in various locations within the community. Older community members were invited personally by the core group. Workshops were limited to 25 participants each day, and included at least six members of the core group. Participants could

attend if they were at least 10 years old; there was no upper limit on participant age. Children under the age of 16 were required to have an adult present due to the use of woodworking tools in the art-making process. The workshops were planned to have the same group attend throughout the three 2-day workshops.

The workshops began with time allotted for explaining and signing the consent forms and allowing for late arrivals. There were plans to record and photograph the workshops but they were abandoned when most of the participants refused to be recorded or photographed. Participants were concerned that recording their voices and photographing their art would disrupt the sacred and spiritual nature of the story, the art, and the commentary about both. They also had cultural privacy and cultural appropriation concerns. However, notes were allowed to be taken during the workshops as well as comments.

The first 2-day workshop took place in late November. An elder began the Snow Snake teaching experience by telling a story. Participants were asked to draw their favorite part of the story. Next, a community member facilitated a talking circle, using prepared questions to start a conversation (Wilson, 2008). Sharing artwork with reflections about how the experience might reflect their own lives was encouraged. In the second workshop, the elder led workshop members into the woods to look for tree branches that could be turned into snow snake game lances. Participants returned indoors to strip the bark from the branches, while hearing the story again. After another opportunity to make art in response to the experience, a short semi-structured talking circle concluded the day's activity, facilitated by a community member.

Two co-researchers (one a community member and myself, a non-community member) wrote notes during and after the workshops and debriefed with one another and the storyteller afterwards. We discussed conversational and snow-snake decorative themes, and any drawings

produced, making notes for later assessment. Art works made during each workshop (which were drawings in response to the stories and the snow snake sculptures) were studied by the co- researchers and participants but not photographed.

The second workshop took place in late December when the snow was deeper. The workshop began with telling the story again. The aged and dried sticks were decorated by the participants using acrylic paints, followed by another talking circle facilitated by a community member. The following day, participants completed the snow snakes and created the playing course in the snow. Participants in teams were led by an elder in playing the game. A short talking circle concluded the day.

The third and final workshop was held one week later, facilitated by a community member who told the story of the snow snakes with the help of participants. The game was played, followed by a third opportunity to create response art to the experience. When we returned to the recreation center, we decided to arrange the snow snakes in a circle to admire our work. After some discussion among that day's participants, we re-arranged the snow snakes in accordance with a particular section of the medicine wheel (discussed below) to which each participant thought their snow snake belonged. Both days concluded with a talking circle and smudging.

Data Analysis. During the month-long project, I met with the core group on a weekly basis to discuss what and how they wanted to learn from the knowledge created by the community in the project, according to our pre-established goals. Because the participants were not comfortable with a fully heuristic process of dialogue with the art or with personal contemplation of the process as a whole, we agreed to develop a more specific research boundary that structured questions in accordance with the medicine wheel. The use of the medicine wheel as an assessment tool can be empowering for Native American community

members, allowing a framework to give voice to their personal experiences (Montour, 1996). Both the talking circles and the medicine wheel structure were determined by the co-researchers to be an appropriate method to gain each participant's subjective perspectives that they might discuss on their own terms and in their own words (Rodwell, 1998; Wilson, 2008).

We decided to use the medicine wheel to guide the talking circles' questions at the end of each workshop (Cochrane, Marshall, Garcia-Downing, et al., 2008). We also agreed to allow discussion to go where participants wanted it to go. The talking circles were facilitated by two members of the core group known by all participants. Talking circle questions were developed collaboratively with the core group to evaluate learning and decolonization goals. We looked at the medicine wheel in the way that the co-researchers wanted it interpreted for the research project and created questions based on that interpretation. We decided to determine the questions based upon the wheel as a whole, rather than parsing out questions from each of the four domains, because many of the questions we wanted answered could fall into several or all of the four quarters. Based upon the medicine wheel as the sum of its four parts, (Montour, 1996), the questions were as follows:

1. What did the elements of the workshops make you feel about yourself?
2. What will be necessary to make the traditional story and game a part of the community?
3. What might be barriers to allowing this traditional story and game to become a part of the community?
4. How did the art-making contribute to the experience?
5. How did hearing the story every day contribute to your art-making process

Finally, the last question was whether there was anything more to talk about. The opened-ended quality of this last question was intended to prompt the discussion toward any observations or concerns that may have come to participants' attention during the course of the workshops and the talking circles.

As a noncommunity member of the research team, I observed all workshop activities and recorded discussion topics and answers to questions by participants. After the workshop series ended, I contacted participants and asked them to confirm their comments as recorded. Requested changes were made and participants were allowed to add commentary. After the comments were confirmed, they were typed and prepared for analysis by the co-researchers.

The co-researchers met to read through all of the collected data (Weiss, 1994). Data was grouped into themes based upon the questions and topics from the talking circles. Themes were broken into groups of responses made in each talking circle, and into responses that were similar across all the talking circles. The co-researchers noted common themes and their relationship to the four medicine wheel themes. They discussed any questions they had and worked to reach consensus regarding how the commentary would be coded. According to Jacobs (2008), the thoughts, interpretations, and beliefs of individuals are as important, if not more important, than prevailing cultural norms when assessing qualitative data.

We next worked on outcomes. The data from the talking circles were regrouped according to the four parts of the medicine wheel to identify evidence of outcomes. Co-researchers worked together to agree on where within the four domains of the medicine wheel the data sets should fall (Arambula & Randall, 2014).

A final step brought the data analysis to the elders who had facilitated or contributed information about the snow snakes. Remembering the game from their childhood, the elders, co-

researchers, and I discussed the workshops, how the story and the game were received, and how the art informed the process. We were then directed by the tribal elders to discuss the story with a tribal storyteller, who met with us and talked about the meaning of several aspects of the story that we did not completely understand.

Results

The co-researchers sought to discover whether members' investment in participatory art and narrative processes would raise self-esteem for the collective and affect participants' self-perception, personal belief system, and their perceptions of their culture. The results of the participatory action research project suggest that workshops were experienced as positive for the participants. We found evidence of the following outcomes: (a) community ownership of the process of inquiry; (b) recognition of the spiritual nature of traditional story, art, and game playing; (c) insight from reflecting on the art and the art-making process; and (d) knowledge drawn from traditional practices.

Community Ownership of the Process

The entire PAR project was impacted by community ownership of the inquiry. The core group (comprised of tribal leaders, members, and elders) invited my participation as an art therapist, developed culturally appropriate methodology, and framed the research questions. Thus, the community had a significant investment in the project and used the project to create community ownership of traditional values. For example, the interest of the elders in rebuilding the knowledge of the game was not anticipated by the core group. Their strong participation and interest in the inquiry process helped build interest by younger community members in learning the traditional game. Comments from adult participants included, "I will have to practice this and

show my old Aunty that I'm as good as her father was," indicating the importance of elder participation.

Recognition of the Spiritual Nature of Traditional Arts

The workshop series was designed to teach a traditional story and game, which the participants found enjoyable for building relationships across generations. Another, less expected outcome was the community's recognition of the spiritual nature of the experience that grew over the course of the research process. For example, the core group did not anticipate resistance to recording the workshops on spiritual grounds by participants. From what participants learned about the spiritual nature of the process prior to the workshops, they determined that they would only participate if no recording equipment was used. Participants reported a sense of higher self-esteem after having their wishes acknowledged and met. As another example of spiritual awareness, one participant walked directly to a branch as her choice as the basis for her snow snake, then reported that she had experienced a dream vision of the branch the night before.

Insights into Health and Wellness

Workshop participants noted enjoyment of outdoor activities included in the workshop experience. Some described the joy of entering the snowy woods to find just the right branch for their snow snake. The experience of creating the throwing track and of playing the game was tiring and required strength as well as skill. Several participants mentioned that they would practice their throwing technique by "building my throwing arm."

Knowledge of Traditional Practices

Learning about traditional practices was an important aspect of the project for community members. This knowledge ties the PAR experience together holistically as a reference for education and self-esteem, personal and community determination, personal choices, and coping

skills. Comments noted during the workshops like, “see, Dad, I can make this and show it at school! And, I’m going to tell the story that goes with it.”, and, “I need to draw out my thoughts about the snow snake design,” point to multiple domains of growth from the workshops.

Participants noted their experience in the workshop as “life changing” in terms of their interest in learning more about the Potawatomi’s culture and traditions. They reported that they made private beadwork to commemorate their newfound knowledge, as a way to honor a new understanding of life. Rather than compartmentalizing the effect of the workshops within the four medicine wheel areas, community members may have instead been looking for the wholeness that comes from the four quarters balanced.

Discussion

This study sought discourse to assess the therapeutic effects of story as a framework for art-making within the context of decolonization of a Potawatomi tribal community. The assessment found that participants in the study identified indicators of increased perception of their traditional culture, raised self-esteem, and changed self-perception. Information about a change in their personal belief system did not seem to be forthcoming within the context of the workshops, however. When asked about that aspect of the research, respondents seemed unable or unwilling to explore that aspect of learning within the context of a talking circle in public workshops.

With participants spanning such a great age range, responses were reflective of developmental status, and of different views based upon how different generations view their traditional culture, how their culture is practiced currently, and an outlook into future cultural practices. Older participants seemed to value traditional cultural practices more than the youngest participants did. Though given respect for their views, the older participants seemed to feel as though they were not heard by the youngest participants in the talking circles. Younger

participants seemed to view the workshops as an exercise in history, rather than an ongoing cultural practice to be embraced. The age range also impacted the ability to play the game, with the youngest and oldest age groups having difficulty playing the game and appearing to becoming easily frustrated. This may be why no community members were seen playing the game on the prepared field after the workshops ended.

Both the art and the talking circle responses were consistent, whether grouped by workshop days, workshop weekends, or all workshops taken together as a whole. Responses within the talking circle to questions about feelings of pride and self-esteem were positive in that every response indicated a feeling of raised self-esteem and pride in their shared heritage and culture.

As noted above, the youngest participants seemed to struggle the most with embracing the traditional game as a contemporary practice. Although they expressed a raised sense of self-esteem in learning the traditional game and creating the snow snakes, they often referred to contemporary video games in their art-making and in commentary in the talking circles. Elders participating often needed definitions of references to these video games, provided by the young participants. I was not prepared for the intrusion of contemporary gaming into the traditional game. After some discussion with community members, we decided together that this was noteworthy, in that the culture of any community is fluid and constantly evolving, even as the community strives to keep its traditional culture intact.

I must note several limitations within this study. The number of participants in the study was small and confined to one tribe, with their attending specific beliefs, culture, and history, so this research should not be considered representative of Potawatomi or all other Native American communities. The research was guided strongly by the needs and wants of this specific tribal

community, with strong input that respected their interests in research that may not translate to research interests within a wider community. The fact that I was unable to photograph an art-based process and was not allowed to record audio material throughout the research process may be considered another limitation. The fluid nature of the participatory research model that was evidenced by the fluid nature of attendance at the workshops may be interpreted as a limitation in data collection as well; however, the study was created with, for, and about a community that carries a culture of fluid attendance of public meetings.

Putting aside the possible limitations of this study, the process as well as the art and commentary supports the premise that this Native American community found the experience of hearing a traditional story, creating response art, and reclaiming a part of their heritage affected their perception of their culture as a positive experience. Learning about cultural history through story and response art was positive for this tribal community's members and was considered valuable within the community.

As a non-Native art therapist working inter-culturally with members of the tribal community, I was often surprised by the self-knowledge of strengths and limitations of the community as a whole by community members. Within all of the participatory action research procedures, and all of the years I have spent working with Native Americans, I still had to work on thinking about their wants and needs. I had to look at this process in a new way: was this what I thought they needed and wanted? Was I doing my own form of colonization? In the end, I still don't have an answer to that question. I think the answer may only come with the passing of time.

My experience and the experiences of my community co-researchers and the workshop participants were rich in learning about compromise, and really seeing each other as individuals rather than monolithically as a "culture." Some co-researchers had to overcome preconceptions of

who I am and what I wanted from the experience; their conceptions may be from experiences with other White people or other researchers or therapists from long ago. I had to ask myself if I was helping or just being—so that the research would find its own truth and not mine. All of the co-researchers had to build trust in each other and the process. It was helpful in the process of building trust that I attended community functions and had a long-standing relationship with the community, as is recommended when working inter-culturally with Native American communities (Norton & Manson, 1996; Weaver, 1997).

The project started with an idea of researching how narrative and art-making may help create a change in community members' self-esteem, but became bigger and more whole as the project progressed. One question haunted my work on this research project, from setting up the workshops through offering the workshops and in the heuristic work of viewing the artistic responses, responding with my own art, and journaling on the subject. As assumed by a comment made by an elder early in my research, the question remained: "Are they ready to learn this?" This, for me, was the ultimate question when doing PAR. I wondered, whose research is this?

The research workshops were designed to provide a process of decolonization as well as a research project, and in so doing, the hope was that the Snow Snake game, and the attending making of the snow snakes would become a fixture of community and culture once again in this particular tribal community. Three weekends were devoted to learning the traditional story, making the game pieces, and playing the game, with the hope that the game will spark interest that will be followed by the community in the future. Since the weekend workshops, however, I have not seen anyone practicing the game using the trough built by workshop participants. I hope that the game becomes a part of community winter activities in the future.

Conclusion

PAR within cross-cultural research when researching within a Native American community may help to empower the community and raise self-esteem among community members. In this study, I found that sharing the research process with co-researchers within a participatory research design can build knowledge, community, and a bridge between cultures that may not occur in other research frameworks. When practiced as part of a culturally based intervention, art therapy combined with narrative may help build community, cultural pride, and achievement of social action, wherein people may work together to discover better ways to meet their personal and community needs and impact their personal reality.

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CHAPTER 3: MEDICINE WHEEL ASSESSMENT

Abstract

This article reports on a culturally grounded method for measuring outcomes and demonstrating the effectiveness of services for a Native American mental health facility. This method was developed from a community-based participatory research project involving Native elders and community partners. Through a series of focus groups, community members delineated a culturally relevant treatment and indicators of success by using the four quadrants of the medicine wheel, which is an Indigenous way of understanding life from a concept of wholeness and balance. Focus group results and next steps in the development of a practice-based approach to demonstrating the effectiveness of culturally specific services are summarized. Findings demonstrate the need to broaden definitions of success used to guide the development and evaluation of effective services beyond those usually used in evidence-based practices, as well as the importance attached to Native Americans gaining spiritual understanding and knowledge and skills in traditional cultural practices as essential elements of achieving community-defined outcomes.

The Medicine Wheel as an Art Therapy Assessment Technique With Native American Clients

As a White, non-Native art therapist working with a Potawatomi Native community, I have found myself looking for therapeutic gains that might not be in line with the needs and wants of the cultural community group. I have found it difficult to connect with how my clients think about their surroundings, their relationships with family and community, and how they think about themselves. I have used art to bridge this cultural gap, given that both art therapy and Native American therapeutic practices incorporate art in practice (Junge, 2010; Mehl-Madrona, 2005). However, I am aware of the need to be more culturally relevant in my practice.

Cultural competence has been identified as a key component in providing services to Native Americans (National Aboriginal Health Organization, 2009). Power imbalance, institutional discrimination, colonization, and ongong colonial relationships in the health care relationship all influence the competence of care (National Aboriginal Health Organization, 2009). Lack of cross-cultural competence causes incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment, failed therapeutic alliances, high rates of non-compliance with treatment, reluctance to visit mainstream health facilities when service is needed, and feelings of fear, disrespect, and alienation (Kirmayer, Groleau, Jaswant, Blake, & Jarvis, 2003; National Aboriginal Health Organization, 2009). Gone (2012) noted that half of Native Americans in the U.S. who pursue mental health care drop out after the first session due to belief that traditional talk therapy will not help them.

In many Native American communities, the creative arts represent avenues of emotional, religious, and artistic expression that remain an essential part of the lives of community members

(White & Epston, 1990). Art therapy may provide an opportunity to visually and metaphorically incorporate concepts of spiritualism and humanism that have traditionally been infused in all aspects of many Native American cultures, including the creative arts (Coyhis, 2009). With this in mind, I asked Potawatomi community members what they thought would help in the practice of art therapy with community clients. After much discussion with tribal elders and members (language they use to identify themselves), they requested an art therapy assessment that would be evidence-based and offered clues for future treatment planning, yet met the specific cultural needs of the community. In the process of building a such a tool, I wanted to consider how individuals may be different from one another and the different ways people think in their different cultures. I sought to engage in a dialogue about cultural differences and similarities, what presents as social identity, and how privilege and economic power may be reflected in how people think about themselves and the world, as compared to how I see myself in the world. Together with the community, we created a treatment assessment that reflected cultural similarities and differences in our respective cultures that could work as a bridge for both. We sought to include the larger community in building the tool, as well as their thoughts about how to proceed. We decided that the medicine wheel would be a good place to start. This was going to take more that asking and answering questions. It was going to take in-depth conversation.

Literature Review

Art therapists have increasingly looked to evidence-based practices to be able to offer effective care that can be replicated (Betts, 2013; Burns & Hoagwood, 2002). However, evidence-based practices can be particularly thorny when dealing with culturally diverse populations (Gone, 2013), so it is important that the client be included in the interpretation and assessment process (Moon, 1995).

The problem with showing evidence in art therapy has been with respect to the assessment of change, not the fact that a change has occurred (Gilroy, 2006; Gilroy, Tipple & Brown, 2011), and culture plays a part in the assessment of change. The cultural background of clients must be a factor in a successful assessment process (Betts 2012) such that clients may use both the tool and the assessment process itself for self-improvement (Betts, 2013). In other words, an assessment must not simply be applied in order to dictate results but instead should foster investment in the process of self- or social transformation.

But what must we consider when building a culturally relevant assessment tool for working in the medium of art therapy with Native American clients? Sacket, Straus, and Richardson (2000) concluded that "evidence-based medicine is the integration of best research evidence with clinical expertise and patient values" (p. 1). Portman and Garret (2006) wrote that when providing therapy within a Native American culture, it is appropriate to refer the healing process to constructs of spirituality, often represented by the medicine wheel. These concepts are: (a) Creator, Mother Earth, and Great Father; (b) community, including family and tribe; (c) surroundings and daily life, nature, and balance; and (d) personal values, thoughts, and beliefs. The medicine wheel, described below, shows one way that these four constructs are conceptualized and illustrated in some Native American cultures.

The Medicine Wheel

Many of not most Native American tribes use and interpret the medicine wheel as a tool of healing and a symbol of power (Twigg & Hengen, 2009). Representing how things work, the circle of the medicine wheel is considered a unifying symbol of everything, with an individual's heart at the center. The sacred circle is bisected into four areas that often represent the four directions on the earth, with the center where the sky and lower earth connect at the heart. This

model represents where the individual connects to everything else in the world and the universe (Dapice, 2006). There are usually four colors attributed to the medicine wheel (red, yellow, black, and white); where the colors sit on the wheel varies depending on the interpretation of the wheel in various Native communities.

Known by Jungian scholars as a mandala or universal symbol of wholeness (Jung, 1968), the form of the medicine wheel as a universal symbol for "everything," embraces change (Dapice, 2006). The balance, relationships, and holistic view of the world that exemplify the medicine wheel are an important part of many Native Americans' views of the world (McCormick, 1996). For many Native Americans, a balance of the four areas of the medicine wheel in all aspects of their lives represents health (Chansonneuve, 2007). Passed from one generation to another, the medicine wheel teachings, called "the way of the circle," are expressed through individual Native community customs and traditions (Garrett, 1999).

The Medicine Wheel as a Treatment and Assessment Tool

The use of the medicine wheel as an assessment tool can be empowering for individuals in Native communities and in creating a framework to give voice to their personal experiences. Critical reflection involving the four elements found within the medicine wheel is important when utilized as an assessment process. Art reflections that are based upon the four elements of the medicine wheel can help deepen insight as well as help interpret art made (Mehl-Madrona, 1997).

As a self-reporting tool for assessment in art therapy with Native American clients, the medicine wheel can identify areas in which the therapeutic intervention has been effective (Portman & Garrett, 2006). These identifiable areas may include information regarding desired and culturally specific goals and outcomes. I argue that the medicine wheel approach to art

therapy assessment can help build cross-cultural relationships to gain insight and serve as a cross cultural bridge for the therapeutic alliance.

Mixing Western Therapeutic Techniques With Native American Healing Techniques

Sue, Allen, and Conway (1978) wrote that it is important for therapists to determine what the client wants and needs relating to their culture and identity when working inter-culturally. Culturally sensitive therapists who work with Native American clients should use local traditions specific to their particular community and adapt their practice to meet their cultural needs (Battiste, 2008; Herring, 1997). Relatedly, Archibald, Dewar, Reid, and Stevens (2012) argued that the creative arts in healing are helpful in treating trauma in First Nation communities in Canada:

> All regions of Canada are using creative arts in healing programs, and these interventions are viewed as effective aids to healing. By remaining true to traditional approaches to healing and, often, blending them with contemporary therapeutic approaches, Aboriginal people are successfully addressing many of the wounds of history—historic trauma and the residential school legacy—as well as the personal issues and problems individuals everywhere struggle to overcome. (p. 4)

McNiff (1992) discussed art therapy in terms of shamanic aspects that connect art making to personally sacred, personally important psychological experience. Applied interculturally, it is possible that art therapy can tap into personally sacred psychological experience. Art making may help clients find the sacred personal that their therapist may not be able to see or understand when working cross-culturally. McNiff proposed that shamanic patterns of personal, sacred knowing emerge similarly when clients work therapeutically in the arts. Likewise, Allen's (1995) thoughts about how patterns of knowing (i.e., identifying patterns and themes in art to identify emotions

and choosing specific art materials to express emotion) when creating in art can be utilized to express the personal sacred.

Native American Knowledge Creation

Ide, Dahlen, Gragert, and Eagleshield (2006) wrote that if culture is not included in the research process, the research conclusions may be skewed. Whether in research or assessment, knowledge responds to cultural, social, and material needs of the population of interest. Moreover, each population is unique in the micro-cultural level of experience, community, and practices (Davis & Keener, 2002; Habermas, 1978).

Therefore, the task of healing and change for the provider is one of working collectively and in concert with the people of a community to build knowledge by talking and hearing what they say about their needs and then allowing them to direct their care (Bruyere, as cited in Coates, Graham, Schwartzentruber, & Ouellette, 2007). The mental health goal is healing in such a way that transforms and enriches the community as well as individuals through active participation in the healing process. Specifically, one must focus on relationships within the community as a whole, including those with non-Native community members and non-Native caregivers, and incorporate goals of societal transformation (Minkler & Wallerstein, 2003).

Community members who are invited to be full partners in building their own assessment criteria help build knowledge for all participants and foster ownership of the result. For instance, an assessment that is based in community and is participatory and collaborative can address issues that are known by community members, while not being apparent to care providers. In the past 15 years, tribes, communities, and individuals have been increasingly interested in an active role in culturally relevant mental health care (Archibald, Dewar, Reid, & Stevens, 2012). However, assessment seems to be an area where non-Native cultured values and expectations may be most

easily imposed (Betts, 2013). This is why a participatory framework was used to build the assessment tool, described in this article.

Methods

Co-Participants

The assessment building process was designed as a participatory project organized around a series of talking circles made up of adult community members. Co-researchers (discussed below) were comprised of (a) the core group, which functioned as a collaborative research team with representatives from tribal leaders, elders, and the community; and (b) focus groups (referred to as talking circles) who helped to select culturally appropriate assessment methods and met to evaluate the assessment instrument goals. All participants were informed of their rights and protections as co-researchers and were provided with details of the project's purposes, procedures, recording of data (which they could refuse), expected duration of participation, risks and benefits, and the voluntary nature of participation. All participants provided their written consent (Appendix A).

When co-researchers and participants trust each other and the researcher, there is a greater likelihood that they will want to participate in a research process. In this case all participants were well-known and respected partners in the community. Community members whom I knew from my community outreach work provided a base from which to build the co-researcher relationship. I began the process of creating the assessment building team with a visit to a prominent elder in the community who was helpful in directing me to other elders for background context for the proposed project.

Procedures

Participants in the assessment building team were recruited from community-wide invitations via individual contacts. A series of twice-weekly talking circles were planned for 4 weeks to take place a total of 8 weeks. At least six members of the core research team, including one elder, were present at each talking circle (Table 1). Participants could attend if they were at least 18 years old, and there was no upper limit on participant age. The talking circles were held in the community recreation center.

The talking circles began with time allotted for explaining and signing the consent forms and allowing for late arrivals. The talking circles were recorded through hand-written note taking because some participants objected to the discussions being recorded. No electronic media was interjected into the informational process.

Each talking circle began and ended with a sage smudging ritual. Talking circles lasted 2 hours, with the first hour set aside for the discussion and the second hour set aside for reflective art making. We agreed that after the talking circle had set the agenda for further discussion, the talking circles would be unguided and that the reflective art made belonged to participants and would not be a part of the data collection. The talking circles were facilitated by two members who were known by all participants. Participants agreed that the goals of the talking circles were (a) community involvement and ownership of their mental healthcare, and (b) a positive outcome toward creating an assessment tool with their input.

Two co-researchers (a community member and myself, a non-community member) wrote notes during and after the talking circles and debriefed with one another after the circles had closed. We discussed themes in the conversations, what we observed of body language, and

how these observations might be interpreted through a cultural lens, and we also made notes for later assessment.

Data Analysis

During the 4-week project, I met with the core group on a weekly basis to discuss what and how they wanted to learn from the knowledge created by the community talking circles according to our pre-established goals of structuring questions in accordance with the medicine wheel (Montour, 2000). We spent one hour of the 2-hour meetings reflecting on the process through personal art making.

As the basis for the assessment, we decided upon four subjects that were aligned with the four areas of the medicine wheel that might guide clients in the art therapy assessment process and build avenues for further discussion. Conversation in the talking circles addressed how community members thought that the areas of the medicine wheel should be applied in the assessment. After the series of talking circles ended, I contacted participants and asked them to confirm their comments as recorded. Any requested changes were made and participants were allowed to add commentary if they wished to do so. After the comments were confirmed, they were typed and prepared for analysis by the core group.

After the eighth talking circle, the core group met to read through all of the collected data (Weiss, 1994). Due to privacy concerns by participants, art that was made as part of the process was considered personal and not referred to as data. Conversational data was grouped into themes based upon the topics in the talking circles and then redistributed into the four quarters of the medicine wheel (Arambula & Randall, 2014). Themes were further broken into groups of responses made in each talking circle and into responses that were similar across all eight talking circles. Core group members noted common themes and their relationship to the four medicine

wheel themes (Table 1). They discussed any questions they had and worked to reach consensus regarding how the commentary would be coded. A final step took the data analysis to the elders who had contributed information to the process for their input into our conclusions.

Table 1:
Medicine Wheel Assessment: Art Therapy Evaluation

Quarter	Indicators	Evidence Examples
Emotional Themes: • Family • Community • Relationships	• How are relationships built within the research process? • How is the community built by community members' participation in the workshops?	• Community ownership of the process. • Researchers are community members. • Multiple generations participated. • PAR process reflects local culture. • Commitment of the community to the process.
Spiritual Themes: • Past & Current Spiritual Practices • Self Esteem	• How are spiritual practices encouraged? • How was self-perception changed in participants in the research process and workshops?	• Recognition and acknowledgement of the spiritual nature of the workshop experience. • Development of the medicine wheel assessment process. • Acknowledgement of raised self-perception.
Physical Themes: • Healthy Body • Healthy Living • Healthy Thoughts • Healthy Behavior	• Is learning new craft and art techniques based on traditional techniques empowering? • Will participating in the workshops encourage healthy behavior?	• Insights were gained through the art-making process. • Workshop participants developed skill during physical activity.
Mental Themes: • Education • Personal Determination • Choices • Coping Skills	• Will participating in the workshops develop new skills? • Does participation in the research and workshop experience create goals for future empowerment?	• Participants learned traditional woodworking skills, traditional colorways, and traditional snow snake decorations and images. • Participants were invested in building skills to play the game.

The following inclusion criteria were used to create the assessment: the meanings of the four quarters and the whole of the medicine wheel for this community, the topics that emerged in

the talking circles, and the assessment objectives of the core group. Topics included personal trauma, colonization, decolonization, and the trauma associated with these issues, and also cultural values. At first glance, these may not look like enduring problems in the community, but they covered a host of issues within the community that include intergenerational trauma (Warren, 20015). Our analysis led to the identification of four useful categories to assess art therapy outcomes based upon the four categories of body, mind, spirit, and emotion found within the medicine wheel.

Results

The co-researchers sought to discover whether community members' investment in a participatory, communicative, and reflective art-making process would collectively build a culturally relevant assessment. The results suggest that the talking circles combined with personal art making were helpful in creating an appropriate assessment tool and was a positive experience for the participants.

Community ownership of the inquiry was evident in the composition of the core group (which had invited my participation as an art therapist) and my development of a culturally appropriate methodology. The community had a significant investment in the project and used the project to create community ownership of traditional values. The talking circles were suggested

by the core group as a way to honor the culture, build investment in the process and outcome, and build a positive-outcome based assessment tool (Barkham & Mellor-Clark, 2003).

Evidence-Based Assessment Tool for Art Therapy

The outcome of the talking circle was the creation of a checklist for use by the therapist using the medicine wheel as a basis for assessment of an art therapy session (Appendix B). The checklist can be used to address the kinds of healthcare issues that were brought up in the talking circles. These include physical aspects (such as how materials are used) and the care that is taken of completed art works. Cognitive or mental aspects include assessment of engagement in the art process; emotional aspects include the quality of affect while creating art and spiritual aspects include expressions of spiritual beliefs through art.

Two additional tools for self-assessment were created. One is intended to stay with the client's chart (Appendix C) and the second assessment is for clients to take home (Appendix D). These tools were designed to include clients in the assessment process, allowing them to interject their viewpoint into the process and, thus, give them ownership of their care.

Cultural and Experiential World Views

Being able to express traditional beliefs and practices within the context of the therapeutic environment was an important aspect of the project for community members. The collective production of a viable assessment tool tied the experience together holistically as a reference for education and self-esteem, personal and community determination, personal choices, and coping skills. The result was a creation of a community-sponsored checklist for professional use and comprehensive self-assessment tools that meet community needs (Lee & Armstrong, 1995).

Community participants were between 20 years and 77 years of age, and responses during the talking circles were notably consistent among all ages. When creating the assessment tool,

participants noted their experience as “empowering” in terms of their ability to direct their own care. Though overwhelmingly positive, the tone of discussions during the talking circles were mixed. Comments noted during the talking circles included positive comments like, “ I love having this thing just for us” and, “Why don’t we do this for all the providers at the clinic?” Less positive comments included, “This is [expletive]. Nobody is going to use this.” After assessing comments, the core group considered how to develop additional clinical assessments based on community needs in the future.

Through collaborative discussion, the core group and I also developed medicine wheel-based worksheets to be used by both a therapist and client in conjunction with the assessment guide checklist. These medicine wheel evaluation guides were created so that clients can participate and have power in influencing care decisions.

The resulting three medicine wheel assessments work together. The first tool (Appendix B) is a form to be filled out by the therapist when viewing and discussing the artwork with her client. Themes follow the four quarters of the medicine wheel, to encourage the therapist to look for meaningful connections, build discussion, and plan for future treatment. The self-assessment medicine wheel tool (Appendix C) should be completed by the client and therapist together to build consensus in health decisions. The art therapist’s checklist may be a referral choice in filling out this assessment tool. Finally, the My Self-Assessment tool (Appendix D) should be completed by the therapist and client together as a reminder of plans for care, with the art therapist’s checklist and the self-assessment medicine wheel used as reference. This assessment goes home with the client.

Discussion

In building the final assessment instrument we decided to look at the medicine wheel as a whole rather than compartmentalizing the talking circle responses within the four

medicine wheel areas. The core group expressed deep satisfaction with this result, and noted that they would discuss this further with tribal elders.

Application of the Medicine Wheel as Assessment

Using the Wheel to Develop Goals and Activities. The medicine wheel can be used as a support for clients in finding meaningful themes to use when expressing their understanding of their therapeutic process. Seemingly abstract in concept, the medicine wheel becomes concrete through artistic inquiry (Running Wolf, as cited in Davis, et al., 2002). Used as an assessment tool, the four divisions within the medicine wheel link expression with therapeutic outcomes.

The attributes of the four areas of the medicine wheel were determined by interpretations from the specific Native American community with which I was working. Because there is some need for interpretation beyond the attributes listed in the Medicine Wheel assessment, which might default to Eurocentric therapeutic goals and diagnoses, my co-researchers and I discussed how to further develop the Medicine Wheel as a heuristic evidence-based assessment (Twigg & Hengen, 2009).

Using the Tool. In my practice with the community's healthcare center, I now use the tool in culturally-sensitive ways. I may focus on interconnected therapeutic outcomes while maintaining an organized framework for analysis. Sometimes connections between art therapy and the medicine wheel are obvious and sometimes they are obscure. In every step, I ask the client which quadrant they believe their thoughts about artwork belong, keeping the interpretation of the art well within the province of the client and his or her culture. For instance, questions and statements to encourage more art making as adjunctive to the original image might include, in the spiritual realm: How does the image relate to your spiritual beliefs/culture/faith? How does this

image reflect your spiritual practice/beliefs? Please draw an image from a traditional story that reflects what we have been talking about.

In the physical realm: During this art process, what were some of the boundaries you believed would keep your personal story from affecting your daily life? Draw images of some traditional activities that you participate in. Draw images that reflect good/bad things about drug and alcohol use. Draw an image of your perfect house/lifestyle.

In the mental realm: How does this image reflect self-acceptance/your feeling in control of your life? How can we redraw this to create an image of a healthier/different outcome? How does this image help you to visualize the future? How might you make another image that reflects another aspect of your culture that reflects cultural pride?

In the emotional realm: How would you represent a healthy role model? Draw an image of your family during a celebration. What might be another/healthier way to celebrate? Answers help in the assessment of the therapeutic intent, the efficacy of art as a liberator of thought, feeling and understanding, and the efficacy of the art to initiate a conclusion.

The examples above exhibit how the medicine wheel may provide an assessment framework. It creates an opportunity for art making that falls within the culture of a particular Native American community and is now helping me to work cross-culturally, bringing a deeper understanding of my client's culturally specific therapeutic process for both my client and me.

The medicine wheel as an art therapy assessment with Native American clients was created between a community art therapist and a Native American community that had asked for an assessment tool that represented their beliefs. We agreed that an assessment that encompassed basic ideas of their culture could be used in an inter-cultural art therapy practice with other Native American communities that adhere to similar beliefs related to the medicine wheel.

Although this assessment has been developed with and approved by a Native American community, it has not been independently evaluated research for the purpose of use beyond the specific community in which it was developed. It is unknown whether this assessment may be appropriate only for a small profile of clients. However, it should be noted that it is unethical to appropriate Native American cultural practices and therefore the tool should not be used as a therapeutic assessment with non-Native clients.

Conclusion

The use of the medicine wheel as a therapy and assessment tool in art therapy offers valuable service to Native American clients. The medicine wheel is a key concept within many Native American cultures and therefore is theoretically grounded for use with both the client in art therapy, as well as for the art therapist's insight and understanding. Clients who have been exposed to the assessment in art therapy have reported to me that they have applied the same medicine wheel assessment criteria to other parts of their lives with success.

The medicine wheel provides a frame of reference for art therapists working with Native American clients, allowing clinicians to bridge a cultural divide in making meaning of the client's responses. The intention of the medicine wheel in assessment is two-fold: that of respecting Native American culture and being credible to the Native American community, and providing a framework of assessment of the efficacy of therapy for the art therapist. The assessment of effective treatment may provide information about the effectiveness of treatment outcomes, as informed by self-report within a specific Native American cultural milieu.

When approached from the Western or Eurocentric therapeutic perspective, the medicine wheel as an assessment tool helps therapists offer respect for clients and their culture, while encouraging a feeling of safety and understanding of art therapy. Used as a

teaching, learning, and cultural bridging icon in the art therapy studio, the medicine wheel represents a secular assessment tool and is not a spiritual religious icon.

Using a cross-cultural educational opportunity wherein I had the support and input of tribe and community members, I worked with an assessment process that included traditional cultural icons and ideas of health and care combined with art process as a form of assessment. The process used the medicine wheel as a way to encourage the art process, the stories that may emerge from the art-making process, and as an evaluation process. The results demonstrate the benefit of broadening definitions of treatment success to provide culturally effective service.

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CHAPTER 4: A VIEWPOINT FROM AN ART THERAPIST

Abstract

A White art therapist working in a Native American community describes her journey from thinking that she is not discriminatory in her art therapy practice to understanding the nature of discrimination. Overt instances of discrimination are explored, with the underground nature of discrimination revealed to her through story and conversation with a Native American elder.

A Viewpoint From an Art Therapist and her Accidental Good Heart

I work as an art therapist offering outpatient mental healthcare outside of my own culture for a Potawatomi community mental health facility in northern Wisconsin. My practice is based on working as a culturally sensitive art therapist, combining Potawatomi and Ojibwa cultural and historical teaching stories with art making as a therapeutic response to intergenerational trauma resulting from a long history of colonization. In my work I combine traditional, spiritual, and cultural Potawatomi and Ojibwa therapeutic and educational narrative practices (Mehl-Madrona, 1998, 2005, 2008) with Western psychological treatment theory and modalities. As a professional practitioner, I have always tried to act as a bridge between cultures, assuming that the interactions of the artist and the art, and the viewer and the viewed, together create healing that bypasses cultural differences.

The Circular Nature of Some Native American Belief Systems

As I understand Native American cultural beliefs, one core belief is that everything is connected. Another core belief is that things like time, creation, people in relationship, and experiences are cyclical; everything moves in a circular rather than linear fashion (Dapice, 2006). This circular system represents balance, movement, return, change, and transformation (Arbogast, 1995), which are concepts that can be applied to the transformational quality of art therapy (Campbell, Liebman, Brooks, Jones, & Ward, 2007; Scheitzer, 1997). McNiff (2004) wrote about the similarity of Native American perspectives and art therapy, in that

> The artist and the shaman go to the heart of the inner storm and enact its furies in a way that benefits the individual and the community. The end result is not just emotional catharsis but deepened insight into the nature of human emotion. (p. 187)

Applied cross-culturally, art therapy may likely be tapping into personally sacred psychological experience, facilitated in circular fashion occurring between the therapist and client. Art making may help clients find the sacred personal that others may not be able to see or understand.

As a White woman working with Native American clients, in my practice I must consider the impact I may have on the therapeutic relationship and what my proposed art-based intervention might have in light of potential colonization (Braveheart-Jordan & De Bruyn, 1995). In support of competent cross-cultural practice, self-reflexive questioning of my intent and imposition of values has been constant in my practice. As I have gradually strengthened my relationships with the leaders of the tribal community, I have tried to provide openings for clients in art, rather than assert my own meaning (McNiff, 2004).

Looking into the spaces between their stories and art therapy and within the metaphoric "overlaps" or spaces between our shared experiences, I thought that I had found a way to support my clients' personal and communal healing. Essentially, I offered my "good heart."

Over the years I have been told many times by my clients that I have a good heart. The meaning seemed clear: I am accepted as a valuable caregiver within the community and community members appreciate my contribution. They do not view me as a colonizing interloper (Smith, 2012). Being seen this way is an important aspect of offering art therapy within the communities where I work. It helps to facilitate the therapeutic alliance and offers the possibility of a genuine relationship between community members and me.

Intergenerational Trauma and Colonization

Native Americans have experienced a sustained assault on their culture and independence and culture since early contact with White and European cultures (Chansonneuve, 2007; Fournier and Crey, 1997). An estimated seven million Native Americans resided in North America when

first contacted by European explorers (Chansonneauve, 2007); within a few hundred years after contact, more than 90% of those seven million people were dead from diseases such as smallpox, measles, and influenza, calamities such as war, theft of property, displacement, poverty, and starvation (Chansonneauve, 2007, Duran & Duran, 1995). The concept of intergenerational trauma from the effects of the contact between White and Native American peoples and cultures has been explored more fully within the past 20 years, and is considered a form of PTSD (Adams, 1995; Braveheart-Jordan & De Bruyn, 1995; Lederman, 1999; Waldram, 1997, 2004).

Root (1992) wrote that intergenerational colonization trauma, specifically trauma from discrimination, oppression, and racism, is understood to be a strong informing factor when considering current deleterious cultural norms. She explained that people and communities become inured to the effects of trauma passed through generations trauma when many community members suffer with the same traumatic history, calling it "hidden trauma" (p. 256). Described as a "matrix of traumatic experience" (Dutton, 1998, p. 1), the ongoing effect of traumatic colonizing experiences can lead to the view that the world is unsafe for everyone and that response to the fear of not feeling safe becomes dysfunctional for communities as well as individuals, thus perpetuating trauma that is difficult to define (Kirmayer, Brass & Tate, 2000). Community cohesiveness is broken and community members don't seem to know how this has occurred, or why. According to members of some Native American communities, this is a description of intergenerational trauma.

My Accidental Good Heart

I grew up in an almost totally White community. My neighbors were White just like me. The school I attended had two Black students who were a matter of curiosity to the rest of us. They were always in other grades and other classes, so I never really got to know them.

My mother hired Black maids who came weekly to my little community on the bus; they were kind and deferential, and probably overqualified for the kind of jobs they could get. I remember being mystified by my mother's admonition not to touch their skin to see if the color would rub off. "Why would I do that?" I wondered. Later there was the greater lesson in discrimination when I overheard one maid trying to get bus route information over the telephone. I remember her soft Southern speech that singled her out as "different" from White people in the community, and she was rudely given the wrong information. When my mother called back to get the information, she was given the right bus numbers.

Through college, many indignities of discrimination because of otherness passed through my life, but few affected me. I simply would have none of it. I did not see the differences in other people. It wasn't that I could not see them; I would *not* see them. One time I had to make a police report and was roundly chided for not mentioning that the people I saw were Black. "Really, what does it matter what color they are?" I thought.

After college I found work as an art therapist with a Native American tribal community. Like many other White people I knew, I was intrigued by this different culture from mine and by people who seemed a bit exotic. I had little knowledge or understanding of what "this culture" meant or of Native American history, or life in Native American communities today. However, armed with a belief in the healing power of art therapy, and my belief that I am not prejudicial but rather than I had an understanding of client-guided care, I forged ahead.

I worked hard to learn about the Native American community where I worked. I read about the shared colonial history of Native Americans and Whites in the United States, and read about the particular Nation I was working with. I attended language classes and I learned culturally relevant art skills to "meet them where they are" rather than expecting my clients to

Function in a world that was comfortable to me but perhaps foreign to them. I got to know community members and heard their stories.

After two years, I was accepted by the community as a person with "a good heart." I took this to mean that I was practicing art therapy from the point of view of my Native American (specifically, Potawatomi) clients; always taking into account their cultural needs and beliefs. I saw myself as a culturally sensitive therapist who did not impose my cultural beliefs on my clients. My practice flourished and I felt confident in my work and in my outreach into another culture. I liked hearing that I had a "good heart," but there was something in that phrase-reserved for White people-that just didn't sound like my impression of my work there.

After working in the community with my good heart for seven years, I embarked on research in which I interviewed an elder of one of the tribes I was working with, looking for insight into tribal history. I had in mind a project that I wanted to offer his community. It would involve a reintroduction of crafts not currently practiced that had been a part of community life in the past. We discussed the history of colonization and how it has impacted the Potawatomi. When we touched on my part as being a White woman working in a Native American community, the story he told me and the question he asked at the end of his telling helped me to understand at last why I was called a person with a good heart.

The elder told a story of how a White man with a good heart had once come into the very same community with a gift of money for those community members who did not have enough wood to heat their homes. The man thought that what community members needed was money to buy the wood they lacked, so that their lives would be easier. Then the man with the good heart left the community, thinking that he had solved the people's troubles. The people in the community thought that they would now buy all the wood that they needed to warm them through

the winter; they did not chop wood to prepare for the snow and the cold. Having no way to get to a place where they could spend the money, they burned it all for fuel in the next cold winter. Many in the community died from the lack of heat the money gave off.

I have a good heart, I mean well, and am open to the community. But as a White woman, I am not a community member and can never know what its members think and feel, and how they understand their world. I knew this intellectually before my encounter with the elder, but suddenly I knew it with my heart. Now I saw that with my good heart, I had stepped into the role of colonizer in my great desire to be the implementer of an agenda to reintroduce lost culture to the tribe. As we discussed the proposed project, the elder mentioned a few words in passing that affected me greatly: "but are they ready for this?" With those six words my eyes were opened to whether this was my project, or theirs. Was I really offering client-centered care or was it therapist-centered care that I was committed to? My good heart was broken; I cried (Figure 1).

Figure 1. *Good Heart.* Digital collage

The Broken Heart and the Glue that Fixed It

It is important to understand that each Native American community is unique in the micro-culture of experience, community interaction, and practices, and that there is no "one" Native American culture (Davis & Reid, 1999; Habermas, 1978). Much writing and that has discussed working cross-culturally with Native American clients is by non-Native American therapists theorizing about the therapeutic needs of Native Americans as a monolithic culture and without recognition of cultures specific and unique to individual communities (Smith, 2012). This has discounted the individual nature of tribe specific cultures and communities.

Fortunately, more recent information about working cross-culturally in Native communities has centered on input from members of those communities with resultant culture-specific working information. Ladd (as cited in Smith, 2012) wrote of the differences

between various Native American cultures and how they may be different from White cultural knowledge systems:

> [They each] contain their own unspoken rules as to what can or cannot be said and how, when and where. Each therefore, constructs cannons of truth around whatever its participants decide is admissible evidence, a process that in the case of certain prestigious discourses, such as those found in universities, medical establishments and communication media, can be seen as particularly dangerous when unexamined, for these then come to determine what counts as knowledge. (p. 76)

Dufrene (who identifies as Powhatan-Renape Native American) and Coleman (1994) looked at how cultural-specific archetypes that inform both culturally-bound communities and are personally significant to community members indicates the necessity that therapy be culturally specific. Discussing the connection of art therapists and contemporary Native Americans as a product of both dominant and Indigenous North American cultures, they concluded that art therapy offered within Native American communities should based on the needs identified by the tribal community.

Professional and ethical issues that should be addressed with Native American clients include questions about spirituality and how clients think that it might impact the therapeutic process (Herring,1997). Herring explained how client centered care and the creative arts combined with Native American spiritual values might interconnect in order to create a therapeutic alliance beneficial in working within a Native American community.

In the art therapeutic relationship, community members who are active as full partners help to produce a better therapeutic outcome and build community health. For instance, therapy that is based on an understanding of community culture, and is participatory as well as collaborative, can address clients' needs that may be known and recognized by members of the

community but may not be apparent to the therapist. As a process of allowing Native Americans the space to communicate openly and fully from their unique understanding of their culture, therapy becomes a cultural, strength-based system of addressing problems (Laeniu, 2000).

Conclusion

When approached from the Western therapeutic perspective, a good heart is not all that is needed to provide cross-cultural art therapy with Native Americans. Art therapists can respect clients and their particular culture while encouraging a feeling of safety and understanding in the art therapy studio when their clients have agency to express their needs from their own perspective. As a teaching, learning, and cultural bridging practice in art therapy, I must remember that the good heart offered is meeting my clients' needs, and not my mine, no matter my good intentions.

Although non-Native art therapists may not know everything there is to know about Native American cultures, a good heart is a good place to start to build a bridge if we can only see where the heart lies.

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CHAPTER 5: DISCUSSION AND CONCLUSION

As described in the preceding viewpoint chapter, as a White, non-Native art therapist working inter-culturally with members of the tribal community, I was often surprised by the self-knowledge of strengths and limitations of the community as a whole by community members. With all of the research I had done into participatory action research, and all of the years I have spent working with Native Americans, I still had to work on thinking about their wants and needs. I had to look at this process in a new way (Figure 2, below): was this what I thought they needed and wanted? Was I doing my own form of colonization? In the end, I still do not have an answer to that question. I think the answer may only come to that question with the passing of time.

My experiences with my research process, the community co- researchers, and the workshop participants was rich in learning about compromise, and really seeing each other as individuals rather than as a "culture." Some co-researchers had to overcome preconceptions of who I am and what I wanted from the experience; these conceptions may have been from experiences with other White people or other researchers or therapists from long ago. I had to ask myself if I was helping, or just being, in order that the research would find its own truth, not mine. All of the co-researchers had to build trust in each other and the process. It was helpful in the process of building trust that I attended community functions and had a long-standing relationship

with the community as was recommended when working inter-culturally with Native American communities (Norton & Manson, 1996; Weaver, 1997).

Conclusion

I offered a series of art-based workshops, reintroducing a game, complete with traditional game pieces to a Native American community as the final PAR project and, during the process, developed an assessment tool that met the community's needs. The assessment tool development was identifiable as a PAR process because in meditating on and creating art about the process, the assessment tool reflected a PAR orientation and approach, much like the overall project. In other words, I see it as a PAR project within a PAR project. After all, PAR research is a fluid process; participants needs develop and can change mid-project and should be addressed. I think that is why I valued the PAR framework so much. I have always preferred fluid over strict parameters, allowing for needs to be met rather than rules that must be followed.

The heuristic nature of my work in the assessment process was not included the two articles, but is briefly written about in the viewpoint. There was a "heart shift" that occurred during the heuristic part of the process that transformed the way I practice, see myself, and see members of the Native American community in which I work. When the research process was finished I was no longer told that I have a good heart. Instead, I was told that I "get it." A higher praise could not have felt better. I hope to take that new designation into all areas of my life.

The journey of the past several years of doctoral study has seemed both difficult and easy; each taking turns in play within my learning. There were times when I wondered if we were "done yet" and other times that I thought this mysterious, fluid doctoral journey was too easy. I was thrilled when I understood a difficult concept and disappointed in myself when I erected

barriers to learning. Attached to this introduction what are three views that help to illuminate my learning and my process in my journey towards becoming a Doctor of Art Therapy.

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Appendix A

Mount Mary University
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
Art and Narrative Decolonization Project
Anne M. Warren
Art Therapy

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE: I understand the purpose of this research study is to better understand a traditional Potawatomi view of decolonization and the use of art as a part of the workshops. I understand that I will be one of approximately 20 participants in this research study.

PROCEDURES: Interviews will be conducted to gather information relevant to a traditional Potawatomi view of decolonization using art "I understand that I will be audio and videotaped during parts of the study to ensure accuracy. The tapes will later be transcribed and a documentary of the experience s in the workshops may be made. I understand that I mayrefuse to be videotaped during the workshops.

DURATION: I understand that my participation will consist of three 2-day workshops held over the course of three months.

RISKS: I understand that the risks associated with participation in this study include feeling discomfort answering some questions that may be raised in the talking circles.

BENEFITS: I understand that the benefits associated with participation in this study include no direct benefits. However, participation in this study may increase your understanding of this topic.

CONFIDENTIALITY: I understand that all information I reveal in this study will be kept confidential. When the results of the study are published, I will not be identified by name. I understand that any data will be deleted from electronic files or shredding paper documents three years after the completion of the study. Your interviews will be identified only by number and classification. All data will be kept in a locked file in my home for three years after the completion of this project, then destroyed. It is not anticipated that data from this project will be used in future studies. Your research records may be inspected by the Mount Mary University Institutional Review Board or its designees, and (allowable by law) state and federal agencies.

VOLUNTARY NATURE OF PARTICIPATION: I understand that participating in this study is completely voluntary and that I may withdraw from the study and stop participating at any time without penalty or loss of benefits to which I am otherwise entitled. I understand that I simply need to state to the researcher that I no longer wish to participate. In addition, if I request I can withdraw all of my data from the project. If I do not request the withdrawal of my data, I understand that it will be used as part of the project and will be kept and destroyed along with all other project data.

CONTACT INFORMATION: If I have any questions about this research project, I can contact Anne Warren at [redacted] or [redacted]. If I have questions or concerns about my rights as a research participant, I can contact Mount Mary University Institutional Review Board at [redacted].

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND I AM PREPARED TO PARTICIPATE IN THIS PROJECT.

_____ _____

Participant's Signature Date

_____

Participant's Name (Print)

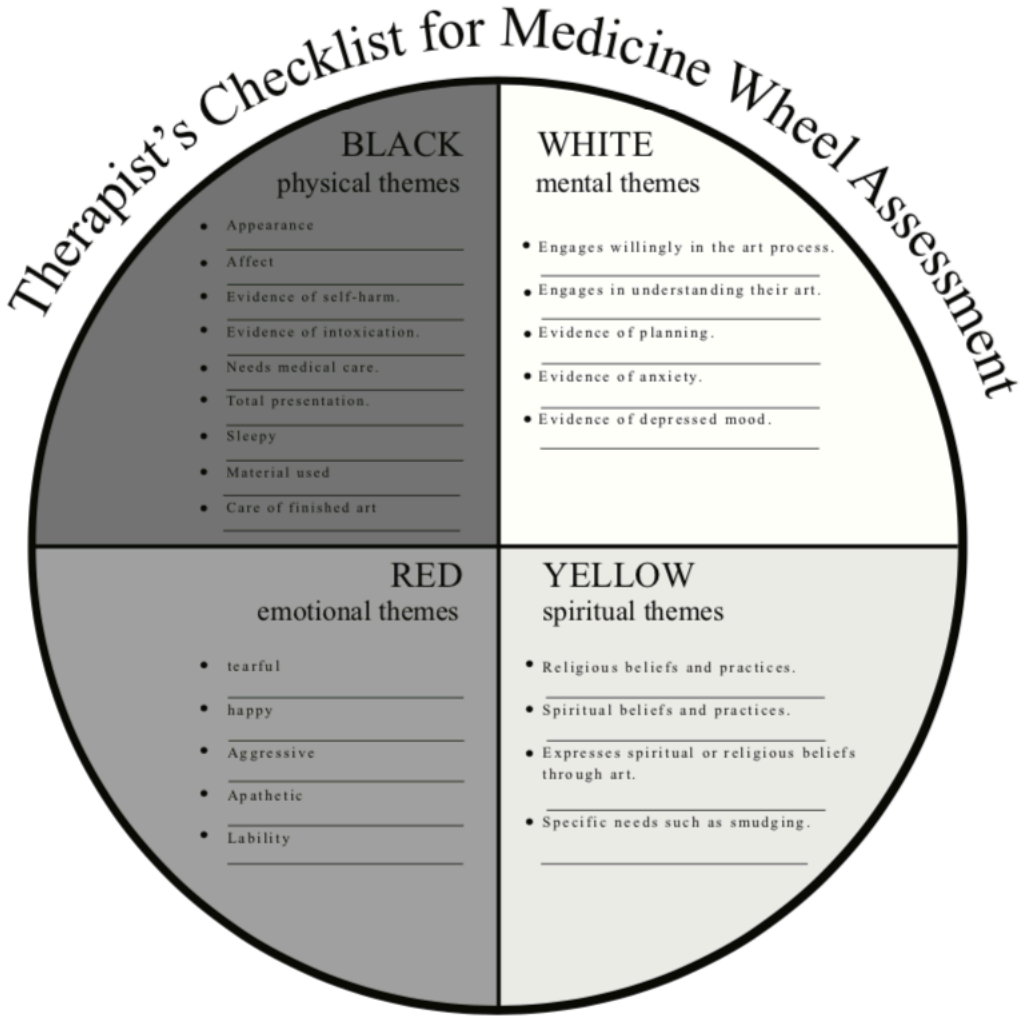
_____ _____

Researcher's Signature Date

Appendix B

Client's Name: _____

_____



Notes: _____

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Therapist's Signature _____

Date _____

Appendix C

Name: _____

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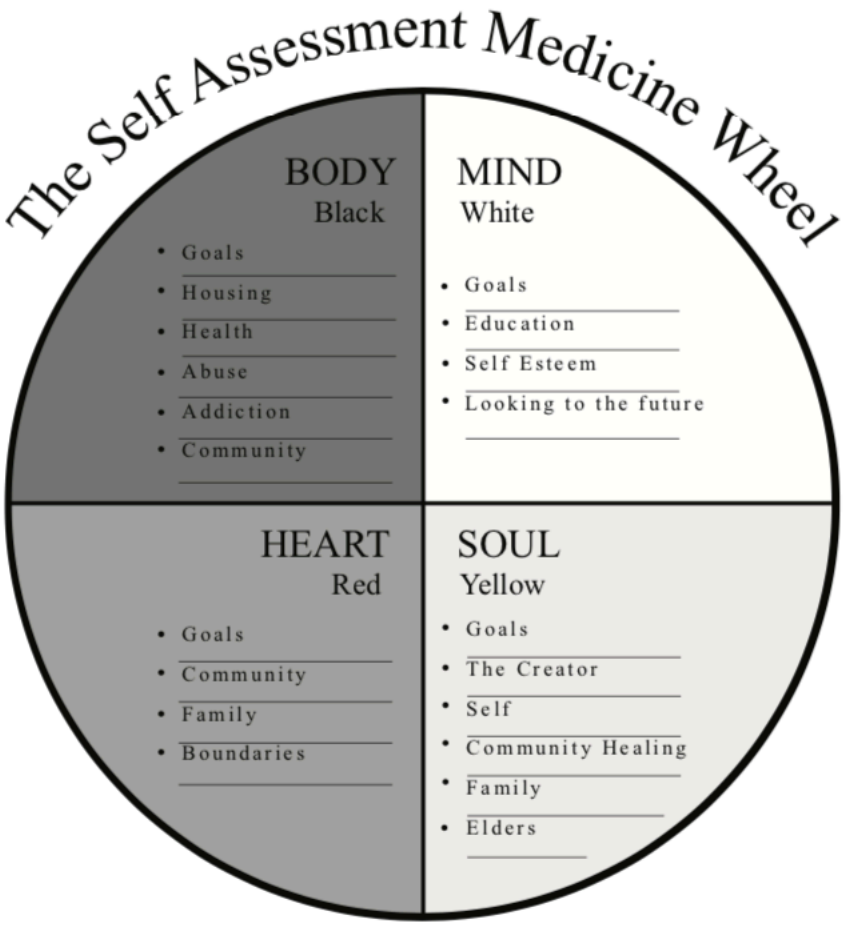


Notes: _____

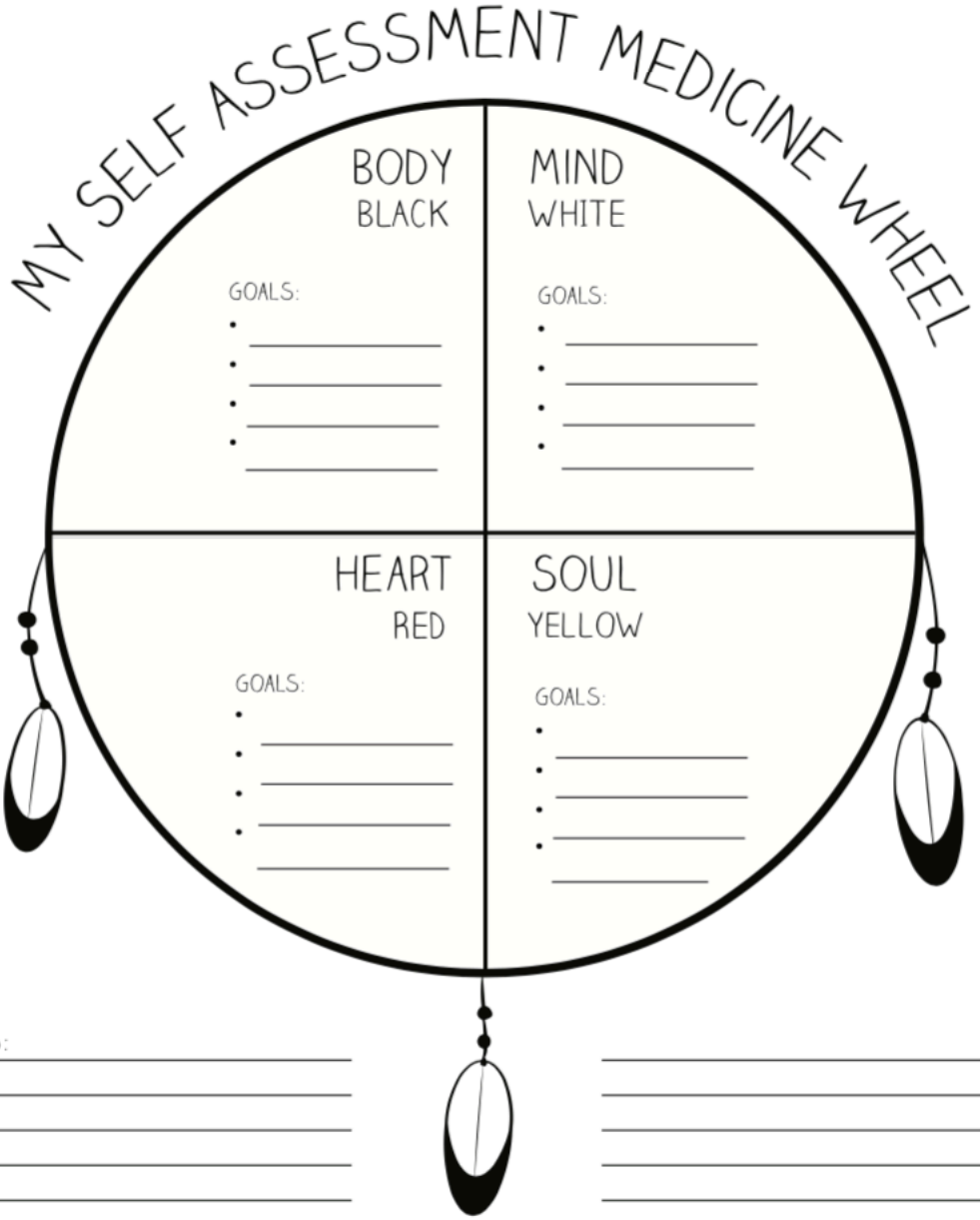
Therapist's Signature _____

Date _____

Appendix D

NAME _____

DATE _____



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