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A Culturally Based Wellness and Creative Expression Model for Native American Communities

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The potential to decrease or eliminate health disparities in Native American communities is enhanced through the inclusion of community members in the development and implementation of prevention and health promotion interventions. Through the process of community participation, culturally relevant and personally meaningful programs are developed. The model discussed here has evolved over several years of working together with Native American community members and incorporates culture, wellness and creative expression into six to ten session curricula for Native American youth and women. Cultural education provided by tribal members and based in one's own tribal history, language, ceremonies and traditional stories, may be protective against discrimination and the impact of historical trauma, thereby promoting personal and community resiliency. Focusing on wellness issues from an assets based perspective, through facilitating effective communication and life skills, substance use resistance and dealing with discrimination, increases the participants' abilities to maintain personal strength and healthy connections. The incorporation of creative expression into the model provides an opportunity to voice one's identity and feelings through a personally empowering process while encouraging community involvement and positive change.

Keywords: Native American communities, health disparities, wellness, cultural education, historical trauma, assets based prevention approach

Community involvement in prevention intervention development and implementation is a means of voicing needs and creating programs that are culturally relevant. This process is likely to gain broad participation in programs and may be more likely to reduce the health disparities being addressed. In addition, this involvement is an active recognition of the knowledge and skills that exist in communities and highlights the importance of working together to create dynamic prevention programs that will be sustainable (Miller & Shinn, 2005). Wallerstein and Duran (2006) describe the benefits and challenges of community-based participatory research (CBPR) in addressing health disparities. They view CBPR as a potential means of making positive changes in community health outcomes, while improving community members' own health through the empowerment that may result from being part of a participatory process. Although not a perfect response to the abuses and inequities that have occurred with indigenous nations in the name of research (Tuhiwei Smith, 1999), CBPR, and its underlying principles, have brought community researchers closer to working equally with communities and

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collaboratively developing programs that have a positive impact on health. By including community members in every aspect of program development and implementation, culturally sensitive issues are addressed through meaningful methods that apply to the conditions related to the health issues of concern.

During the course of several years of prevention intervention development, the authors (half of whom are Native American) have worked together with Native American community members to create a culturally based wellness model that incorporates creative expression. This model has evolved through implementation with Native American youth and women to enhance health and prevent substance use. It incorporates life skills, wellness education, verbal and visual creative expression and cultural information into six to ten three-hour sessions. Three major components (culture, wellness, and creative expression) are part of a structured curriculum and occur in an environment of empowerment and health that fosters growth, community connectedness and positive changes in health related knowledge, behavior and attitudes (Figure 1).

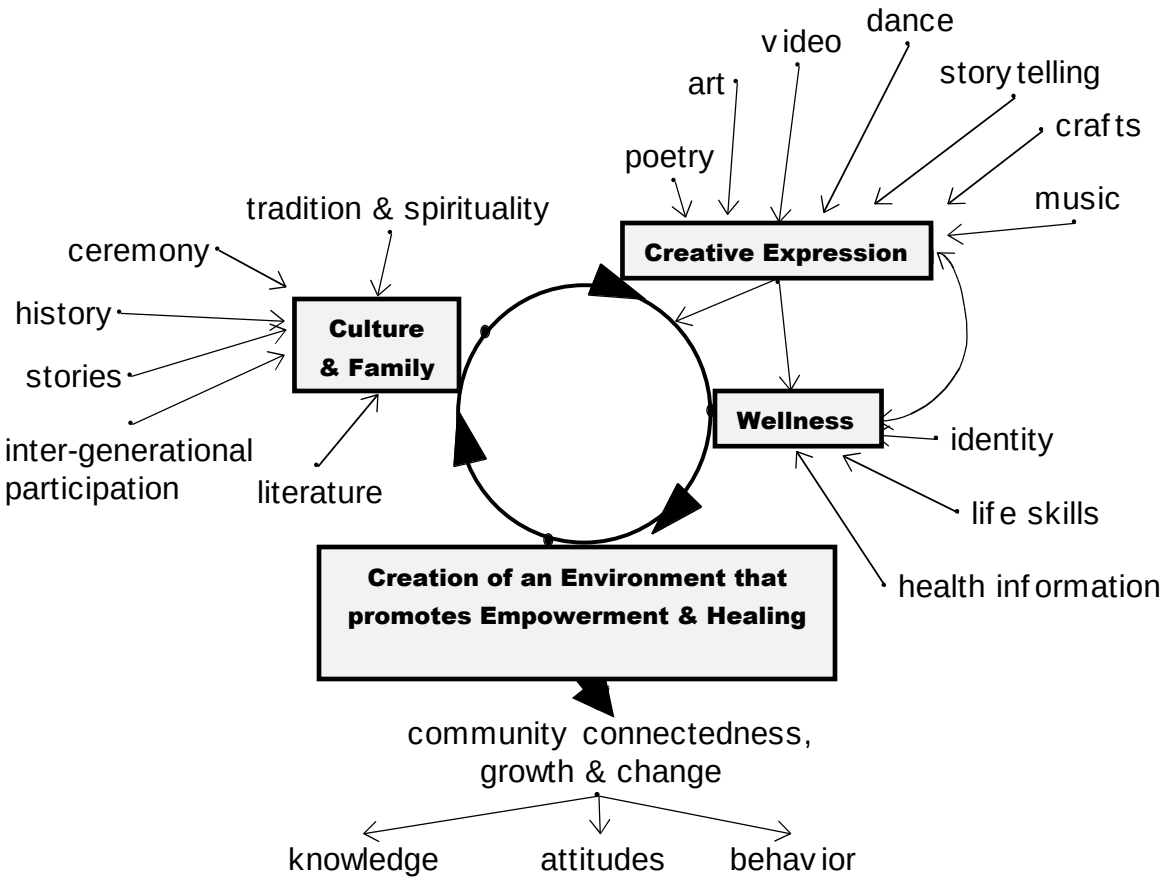
Prior to developing each program component a community-based advisory board is formed. It consists of interested individuals from the community who are willing to provide their time to enhance the health of their community. This is a working group that comes together with the understanding that their purpose is to develop, implement and oversee the program. Sometimes the group members prefer not to be named an "advisory board" and suggest a name that expresses their Native connections. For example, one community advisory group designated themselves as the "Planning Circle." These groups meet on a regular basis with the frequency dependent on the tasks they are accomplishing. While developing a program intervention, meetings are usually held at least once a week for approximately two to three hours. During the implementation phase of a program, meetings occur approximately once a month for two hours.

In addition, the staff who are hired to implement the program intervention as facilitators are always Native American community members. These program facilitators are not only a significant part of the advisory board and the planning process of the program, but they serve as role models to whom the participants can relate as individuals who understand the struggles participants experience in their lives. Adult facilitators, as well as youth peer educators, are viewed as resources and leaders, both in and outside of their prescribed program roles. Further, the incorporation of a variety of Native American community members as guest artists, storytellers, and speakers enhances this assets based prevention approach and is consistent with a collectivist cultural framework.

Cultural Component

Indigenous Nations have experienced varying degrees of dissolution of their language and cultural traditions. They express a need to assure that tribal history, traditional ceremonies, language, and ancient stories are kept alive, passed on and incorporated into the lives of future generations. Some view this loss of connection to history and culture as contributing to a weakened identity and a diminished sense of belonging that results from the ongoing process of colonization and discrimination that indigenous Nations have faced for generations. Whitbeck, Adams, Hoyt, and Chen (2004) describe the depth of cultural loss and transgenerational grief, relating it to historical trauma. They highlight how these feelings continue to affect the daily lives of Native Americans, as well as their psychological and physical health. Davis et al. (2004) discuss how community health promotion must focus on learning that is centered on the cultural context in which individuals live. They view traditional art and cultural expression as a means of integrating the spiritual, emotional, and physical aspects of health and empowering individuals and communities.

Figure 1. Culturally based creative expression wellness model



Other authors have emphasized the importance of cultural identity and enculturation as protection against the trauma, discrimination and stress in the lives of Native Americans. Involvement in traditional ceremony and heath practices, positive identity, and use of spiritual methods of coping are discussed as potential methods of buffering the experience of stress and trauma (Walters & Simoni, 2002; Chandler, LaLonde, Sokol, & Hallett, 2003). Weaver and Braveheart (1999) stress the importance of cultural identity as the core, or center, of individuals and view it as a potential protective factor. Thus, traditional native culture is a crucial component of any health promotion program with Native American youth or adults.

In the model that has evolved through the authors' work with Native American communities, tribal elders, community members and leaders play a major role in the development of the cultural component. They provide resources for historical literature and descriptions of how their people were enslaved / discriminated against by governments and/or ethnic groups in the past. They verify and tell stories that have survived through the centuries that teach about their way of life and the origins of their beliefs. Some have told or written their own stories specifically for the programs, which provide an understanding of how the elders' personal experiences relate to recognizing internal strengths that may be ignored or not

encouraged in the current culture. The history and personal stories are incorporated into the structured curriculum and become an integral part of the program. In some programs, the elders come to speak to the participants directly about their culture and history. This provides a direct learning experience, with the elder being a mentor who models how each participant can survive the trauma and discouragement they face in their lives by utilizing their internal strength and by acknowledging the strength of their ancestors. Such meaningful levels of investment on the part of elders and cultural leaders are an important means of socially binding the program into the community, fostering community ownership, connectivity and support. In turn, program participants have honored cultural speakers and program staff through gift giving, publicly advocating for program activities and volunteering.

Wellness Component

Across the United States, Native Americans experience profound health disparities (Smedley, Stith, & Nelson, 2003; Jones, 2006). These disparities are due to a number of factors, including discrimination. Social inequities and chronic stress linked with discrimination have been associated with numerous physical and mental/behavioral health problems (Williams, 2002; Williams, Neighbors & Jackson, 2003). Health disparities also stem from isolation, poverty, and limited literacy (Berkman et al., 2004; DeWalt et al., 2004; Nielsen-Bohlman et al., 2004; Smedley et al., 2003), as factors that sometimes characterize Native American communities. Therefore, health promotion programs must address the discrimination, stress and hopelessness that Native Americans experience, and they must be conducted in a manner that does not perpetuate the negative stereotypes and inequities they currently experience.

Rather than addressing health disparities from an illness or problem focus, a strength and resiliency based approach provides a positive perspective for participants and others involved in program development (Holden et al., 2004). Inherent in the model presented here is a focus on wellness, rather than illness, which opens participation to all who would like to attend. This focus reduces the stigma generally associated with problem-based programs that typically have the problem/outcome behavior in their names. The programs developed through the use of this model have titles that incorporate Native language and a statement about health. Program titles such as these create an interest in participation and allow recruitment to focus on increasing health and engaging in creative activities, rather than eliminating a negative behavior that may have been a means of coping.

Finally, these wellness programs seek to raise awareness about the interdependence of the individual and the community by discussing models of community change, those that are a cumulative effect of many individuals changing and those that are initiated by the voices of newly empowered individuals (Aronson et al., 2007; Pittman, Martin, & Yohalem, 2006).

Through the wellness component in the prevention model described here, community members have the opportunity to identify the health issues of most importance to them, to define their apparent causes, and to determine how they will be addressed. The community based advisory boards, with input from additional community members, determine the health issues that will be incorporated into the structured curriculum. Although information is provided (through the distribution of handouts, viewing film clips, and role plays) about prevention of some problem behaviors such as unsafe sex, substance use, and alcohol use, staying emotionally and physically healthy is emphasized. In addition, due to early feedback from community members, it was decided that health information would be presented experientially, rather than through a traditional classroom/educational presentation. Perry (2004) has emphasized the importance of including creative and experiential activities in prevention programs

in order to hold the attention of participants and gain their full involvement in the active learning process.

In harmony with descriptions of indigenous education and participatory action research, this learning process can be described as a "becoming" process. It encourages engagement in mentoring relationships, community interaction and becoming a visible and responsible participant in the promotion of community wellbeing (Caldwell et al., 2005; Deloria, 1991).

If there are cultural issues related to how a wellness issue is addressed, the staff and advisory board work together to determine how it can be presented in a culturally relevant and respectful manner. For example, while developing a program for women, it was determined that learning to be assertive in interpersonal relationships would be beneficial to the emotional and physical health of the participants. However, the conventional method of teaching assertiveness was too harsh and was not responsive to the complexity of interpersonal needs. Given the importance of maintaining family relationships and the cultural significance of helping family members and friends through difficult times, learning to take care of and stand up for oneself in close relationships was complicated. Sometimes they were over extended and emotionally and physically burdened by their desire to help friends and family members and the expectation that they would always be available to help when needed. During intensive discussion and consideration of these issues in the curriculum planning meetings, community members created culturally appropriate communication guidelines and role-playing situations that could help women maintain their personal power and encourage self-nurturance while still caring for their family members and friends.

Wellness topics for adult women include understanding the impact of current life and historical trauma, self-esteem issues, coping with life stress, family communication, nutrition and exercise, sexual health, substance use as a means of coping with stress, impact of discrimination in one's life and the importance of education and life planning. There is a focus on the benefits of engaging with and supporting family and community members. Napoli (2002) has discussed the empowering experience of Native women participating in activities together and supporting each other. She emphasizes the positive effects of sharing stories and having meals together, which is a valuable part of the model presented here. It is also important to implement interventions with cultural sensitivity that empowers women, acknowledges environmental and life stress, connects them to their cultural traditions and supports their resiliency. Brown, Abe-Kim and Barrio (2003) emphasize that health practitioners should validate experiences of discrimination as serious sources of stress and acknowledge that spirituality can be a cultural resource for coping with stress and depression. Myers et al. (2002) describe the need to investigate the connections between social undermining, stress, and social support and depression among women. In addition, focusing on resilience and survival strategies that individuals, families and indigenous Nations have used historically can help women connect with their culture and ancestors (Simoni, Sehgal, & Walters, 2004).

Wellness topics for youth include identity and self-esteem issues, relationships and communication/life skills, substance use resistance, HIV prevention and harm reduction, and the importance of education and life planning. Experiential activities, such as skits, craft work and games, are used to provide wellness information and engage participants in an interactive process that facilitates learning. The life skills components are partially based on La Marr and Marlatt's (2002) *Canoe Journey – Life's Journey*, a substance abuse prevention curriculum for Native youth. Their cognitive behavioral skill based curriculum focuses on how to cope successfully with various life challenges and risks through utilization of a canoe journey metaphor emphasizing both the value of personal skills and the community value of interdependence.

Hawkins, Cummins and Marlatt (2004) discuss the importance of conceptualizing prevention and behavior change as part of a continuum. This allows a focus on harm reduction that enhances community outreach, self-determination and learning appropriate ways to cope with high-risk environments.

Additionally, *Canoe Journey – Life's Journey* contains activities related to bicultural competence. In studies addressing substance abuse risk with Native Americans, bicultural competence has been associated with lower risk of substance abuse morbidity and greater success in youth prevention interventions (Faryna & Morales, 2000; Hawkins, Cummins, & Marlatt, 2004). Bicultural competence is the ability to functionally adapt coping skills within both Native American and dominant U.S. cultures. It includes an integrated self-identity in which Native identity and cultural affiliation is maintained while "crossing over" to the dominant culture without threat of social abandonment.

Creative Expression Component

An additional intrinsic aspect of the model is self-expression, which is closely related to the wellness and cultural components. When racism, discrimination and intolerance are personally experienced, one's self or "voice" may be silenced. Self-esteem, wellness, and a sense of mastery and control in one's life, which may be a source of one's "voice" or self-expression, are all diminished by discrimination (Williams, Neighbors & Jackson 2003). Strength based programs that include activities such as media arts, poetry, music, and other means of self-expression provide an opportunity to cultivate one's voice and create an environment where participants feel empowered and can develop many aspects of themselves as they learn to work through life problems (Keeling & Bermudez, 2006; Perry, 2004; Wang, 2003).

A number of studies have demonstrated the usefulness of using creative expression as a means of enhancing health. Emotional expression through writing and journaling has led to improvements in immune functioning (Pennebaker, Kiecolt-Glaser & Glaser, 1988) and physical and psychological well-being (Frattaroli, 2006; Richards, Beal, Seagal & Pennebaker, 2000). Psychiatric treatment programs have been using art therapy for decades and, more recently, some mental health professionals have used discussion of well-known pieces of art as an adjunct to psychotherapy group treatment for depression (Allam, 2005). Great Britain has numerous community arts projects and their Arts Council has recently reported on the positive impact that involvement in art has on health, academic achievement and preventing involvement in the justice system (Arts Council England, 2004). Similar to what is happening in Great Britain, the Rockefeller Foundation has funded several community cultural development projects in recent years (Adams & Goldbard, 2002). In a publication reviewing the benefits of community projects that emphasize culture and creativity, the program director commented that community cultural development projects that bring together the arts and culture play a powerful role in fostering equity and inclusiveness, lifting the human spirit and nurturing social development. Such projects have the potential to significantly change human lives, so there is a tremendous need to adequately evaluate these programs and substantiate the connections between art involvement and health (Hamilton, Hinks & Petticrew, 2003).

The field of entertainment-education is becoming a popular method of intervening with adolescents and young adults (Glik et al., 2002). Through the use of performing arts, as in other methods of creative expression, youth are able to become actively involved in learning how to develop and deliver a health message that will have an impact on an audience. Not only are the participants learning health content related to their message, but the creative method allows them the opportunity to repeatedly express the content, which reinforces its meaning and impact on them. In addition, they are providing a health message to others in a

medium known to influence attitudes and behaviors regarding health issues.

This method may be beneficial because it is not always based on language. Visual and other non-verbal types of creative expression allow individuals to express their feelings and thoughts without the burden of finding the "right" words. Sometimes this may include a connection with traditional arts from their original culture that strengthens their identity and sense of meaning in their lives. Perry (2004) emphasizes that if a creative or artistic context is added to health behavior prevention programs that youth may be more receptive to them and enjoy them more. This could lead to higher retention rates and more lasting outcomes.

A major focus of the prevention interventions implemented through the model presented here has been to engage participants in creative activities related to their indigenous cultural background. As this occurs, they are expressing themselves in relation to their history, identity, and personal experience; they are providing a voice for their emotional and spiritual world. An additional element is one of media literacy, especially in relation to how Native people are represented, stereotyped, and marginalized through the media. The use of video making in work with adolescents has been found to facilitate a celebration of identity, while simultaneously creating an environment to question social norms (Potter, 2006). Questioning through the use of media awareness and video making provides a productive means of examining and coping with sources of anger and internalized oppression that individuals experience. Portions of the media literacy focus frame substance abuse resistance as "radical resistance." Youth are exposed to documentation of the linkages between social oppression, the illicit drug trade, incarceration and community degradation, along with messages of enhancing protective factors on the personal and community level. Video making is a means of integrating knowledge and experience in several expressive modes at the same time: visually, verbally, and through music and narrative (Potter, 2006).

Staff, participants and advisory board members determine what types of creative expression will be most beneficial for the participants. The focus ranges from Native American cultural art experiences, such as making painted murals depicting historical scenes, making jewelry through bead work, and making wood flutes used in traditional music, to filming and editing videos that focus on identity or health issues. Through the use of visual and media arts, participants are able to express the emotional depth of their experience. Frequently the artistic expression activities are directly associated with the wellness topics. For example, youth may practice healthy life skills through creating videos that illustrate the challenges they face and how they might cope with them. The videos the participants create and edit also provide culturally relevant educational experiences for others, including their peers and family members, as they show the videos they have produced in public venues to celebrate their accomplishments. Development of potential job skills and increased self-esteem are additional potential benefits of the artistic expression process.

Conclusion

This model provides a framework for developing prevention and health promotion interventions that will focus on wellness and incorporate cultural and creative expression components. Drawing on community cultural development methodologies, this model also focuses on the benefits of individual and community empowerment to proactively face the daily experience of marginalization and express the healing and sustaining force of cultural dynamism. The integration of cultural, visual and media arts provides a powerful means of increasing cultural identity, community cohesion, and self-esteem and facilitates an environment of experiencing and maintaining physical and emotional health. By addressing social inequalities and personal struggles through creative expression and with community connection, the potential to decrease or eliminate health disparities is enhanced.

The following is a poem written by a Native youth volunteer (Alicia Tellez):

Life's Path

As you grow older life gives you different paths to take
One may be full of dead ends; one may be what you make
It's all about choosing what direction to lead
One full of troubles or one you'll succeed
The one full of bumps may look a little rough
But this is the path that keeps you going, and not giving up
It takes responsibility and a lot of hard work
To reach out from the hardships and come to a perk

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References

Adams, D. & Goldbard, A. (Eds.) (2002). *Community, culture & globalization.* New York: Rockefeller Foundation.

Allam, A. (2005, July 14). When art imitates pain, it can help heal, a therapy group finds.*New York Times.*

Aronson, R.E., Wallis, A.B., O'Campo, P.J., Whitehead, T.L., & Schafer, P. (2007). Ethnographically informed community evaluation: A framework and approach for evaluating community-based initiatives. *Maternal & Child Health Journal, 11*, 97-109.

Arts Council England. (2004, May). *The impact of the arts: Some research evidence*. London: Arts Council England.

Berkman, N.D., DeWalt, D.A., Pignone, M.P., Sheridan, S.L., Lohr, K.N., Lux, L., Sutton, S.F.,Swinson, T., Bonito, A.J. (2004, January). *Literacy and Health Outcomes.* Evidence Report/Technology Assessment No. 87 (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication No. 04-E007-2. Rockville, MD: Agency for Healthcare Research and Quality.

Brown, C., Abe-Kim, J.S., & Barrio, C. (2003). Depression in ethnically diverse women: Implications for treatment in primary care settings. *Professional Psychology: Research and Practice, 34,* 10-19.

Caldwell, J.Y., Davis, J.D., DuBois, B., Echo-Hawk, H., Erickson, J.S., Goins, R.T., Hill, C., Hillabrant, W., Johnson, S.R., Kendall, E., Keemer, K., Manson, S.M., Marshall C.A., Running Wolf, P., Santiago, R.L., Schacht, R., & Stone, J.B. (2005). Culturally competent research with American Indians and Alaska Natives: Findings and recommendations of the First Symposium of the Work Group on American Indian Research and Program Evaluation Methodology. *American Indian and Alaska Native Mental Health Research, 12,* 1-21.

Chandler, M.J., LaLonde, C.E., Sokol, B.W. & Hallett, (2003). Personal persistence, identity development, and suicide: A study of Native and non-Native North American adolescents. *Monographs of the Society for Research in Child Development, 68,* (2, Series No. 273).

Davis, B., McGrath, N., Knight, S., Davis, S., Norval, M., Freelander, G., & Hudson, L. (2004). Aminina Nud Mulumuluna ("You Gotta Look After Yourself"): Evaluation of the use of traditional art in health promotion for Aboriginal people in the Kimberley region of Western Australia. *Australian Psychologist, 39,* 107-113.

Deloria, V., Jr. (1991). *Indian education in America.* Boulder, CO: AISES.

DeWalt, D. A., Berkman, N. D., Sheridan, S., Lohr, K. N., & Pignone, M. P. (2004). Literacy and health outcomes: A systematic review of the literature. *Journal of General Internal Medicine, 19*, 1228-1239.

Faryna, E.L. & Morales, E. (2000). Self-efficacy and HIV-related risk behaviors among multiethnic adolescents. *Cultural Diversity and Ethnic Minority Psychology, 6,* 42-56.

Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin, 132,* 823-865.

Glik, D., Nowak, G., Valente, T., Sapsis, K., and Martin, C. (2002). Youth performing arts entertainment-education for HIV/AIDS prevention and health promotion: Practice and research. *Journal of Health Communication, 7,* 39-57.

Hamilton, C., Hinks, S., & Petticrew, M. (2003). Arts for health: Still searching for the Holy Grail. *Journal of Epidemiology & community Health, 57,* 401-402.

Hawkins, E.H., Cummins, L.H., & Marlatt, G.A. (2004). Preventing substance abuse in American Indian and Alaska Native youth: Promising strategies for healthier communities. *Psychological Bulletin, 130,* 304-323.

Holden, D.J., Messeri, P., Evans, W.D., Crankshaw, E., & Ben-Davies, M. (2004). Conceptualizing youth empowerment within tobacco control. *Health Education & Behavior, 31,* 548-563.

Jones, D.S. (2006). The persistence of American Indian health disparities. *American Journal of Public Health, 96,* 2122-2134.

Keeling, M.L. & Bermudez, M. (2006). Externalizing problems through art and writing: Experiences of process and helpfulness. *Journal of Marital and Family Therapy, 32,* 405-419.

La Marr, J. & Marlatt, G.A. (Eds.) (2002). *Canoe Journey: Life's Journey.* University of Washington & Seattle Indian Health Board.

Miller, R. L., & Shinn, M. (2005). Learning from communities: Overcoming difficulties in dissemination of prevention and promotion efforts. *American Journal of Community Psychology, 35*, 169-183.

Myers, H.F., Lesser, I., Rodriquez, N., Bingham Mira, C., Hwang, W., Camp, C., Anderson, D., Erickson, L., & Wohl, M. (2002). Ethnic differences in clinical presentation of depression in adult women. *Cultural Diversity and Ethnic Minority Psychology, 8,* 138-156.

Napoli, M. (2002). Holistic health care for Native women: An integrated model. *American Journal of Public Health, 92*, 1573-1575.

Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). Health literacy: A prescription to end confusion. Washington, DC: The National Academies Press.

Pennebaker, J.W., Kiecolt-Glaser, J.K., & Glaser, R. (1988). Disclosure of trauma and immune function: Health implications for psychotherapy. *Journal of Consulting & Clinical Psychology, 56,* 274-281.

Perry, C.L. (2004). Getting beyond technical rationality in developing health behavior programs with youth. *American Journal of Health Behavior, 28,* 558-568.

Pittman, K.J., Martin, S., &Yohalem, N. (2006). Youth Development as a "Big Picture" public health strategy. *Journal of Public Health Management & Practice. 12* (Supplement 6), S23-S25.

Potter, J. (2006). Carnival visions: Digital creativity in teacher education. *Learning, Media & Technology, 31,* 51-66.

Richards, J.M., Beal, W.E., Seagal, J.D., & Pennebaker, J.W. (2000). Effects of disclosure of traumatic events on illness behavior among psychiatric prison inmates. *Journal of Abnormal Psychology, 109,* 156-160.

Simoni, J.M., Sehgal, S., & Walters, K.L. (2004). Triangle of risk: Urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS and Behavior, 8,* 33-45.

Smedley, B.D., Stith, A.Y., & Nelson, A.R. (Eds.). (2003). *Unequal treatment: Confronting Racial and ethnic disparities in health care.* Washington, DC: National Academy Press.

Tuhiwei Smith, L. (1999). Decolonizing methodologies: Research and indigenous people. London & New York: Zed Books.

Wallerstein, N.B. & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7,* 312-323.

Walters, K.L. & Simoni, J.M. (2002). Reconceptualizing Native women's health: An "indigenist" stress-coping model. *American Journal of Public Health, 92,* 520-524.

Wang, C.C. (2003). Using photovoice as a participatory assessment and issue selection tool: A case study with the homeless in Ann Arbor. In M. Minkler, & N. Wallerstein, (Eds.), *Community based participatory research for health (pp. 179-196).* San Francisco, CA: Jossey-Bass.

Weaver, H. & BraveHeart, M. (1999). Examining two facets of American Indian identity: Exposure to other cultures and the influence of historical trauma. *Journal of Human Behavior in the Social Environment, 2,* 19-33.

Whitbeck, L.B., Adams, G.W., Hoyt, D.R., & Chen, X. (2004). Contextualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33,* 119-130.

Williams, D.R. (2002). Racial/ethnic variations in women's health: The social embeddedness of health. *American Journal of Public Health, 92,* 588-597.

Williams, D.R., Neighbors, H.W. & Jackson, J.S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93,* 200-208.