Artistic Interventions Toward Healing for Refugees

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This paper was created for Northwest University. Sections of this paper have been used in other unpublished works by the same author.

Acknowledgement

This paper is dedicated to the three lovely souls this world and I lost during my time in graduate school. Sarah was taken by an accident in Africa, Nils a former 14-year-old student from a disease at Fred Hutchison in Seattle, and Tom from Texas took his own life. To Sarah, Nils and Tom: “Good night sweet princes (and princess) and flights of angels sing thee to thy rest” (Shakespeare, 1602).

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Abstract

There are many social and economic opportunities for refugees who relocate to a Western context. Additionally there are usually many agencies and resources that aim to meet the tangible and physical needs of refugee communities. However, there is a lack of healthcare, specifically mental healthcare, support, and soul care. Furthermore traditional Western talk therapy or other mental healthcare services offered in the United States can be expensive, intimidating, un-relatable or unavailable to refugees. By establishing interventions towards artistic healing for refugees, we find that the tools for mental healthcare are democratized and available for all. Drawing upon my own experience, and relying on expert opinion, field interviews and research I will convey values, best practices and methods for successful artistic interventions. Furthermore my paper will outline the benefits artistic healing and how the church can take a vital role in this important work.

Interventions Toward Artistic Healing for Refugees

I. Introduction

There is no doubt that a refugee's experience is painful. There is damage done to the human body, mind and soul that many people will simply not ever be able to understand; we can only try to grasp the vastness and depth of the hurt and pain. During this research process, self-conscious has crept in; what do I know about what it is like to be a refugee? However, after talking to my friend Ambassador Halefom, who immigrated to the United States from Ethiopia, I felt encouraged and justified in continuing this work. Ambassador reminded me that, even though I might have my personal doubts on this subject, this work was important. He wished that during his transition process he had had access to safe places where forms of artistic expression were practiced for increased mental health. Ambassador told me over and over again, "This work is important. This work is important." (A. Halefom, personal communication, January 20th, 2015). This became my mantra. I grasped a small amount of confidence from his encouragement and pushed onward.

This research is intended to be beneficial to aid workers, developers and artistic healing facilitators who are interested and concerned with refugee mental healthcare. My paper will begin by defining certain terms. The research will outline outside sources and expert information gained through interviews and expert opinion. Furthermore it will outline gaps in current refugee care. While alternate forms of healing exist for refugees living in the United States, the research will not only justify the need for more therapeutic options for refugees, but it will also show that artistic healing is the most democratized approach for refugee mental healthcare. The collectiveness of my paper will make the case that artistic healing also has multiple other benefits for the human body, mind and soul.

One of this paper's objectives is not to create a specific curriculum for artistic healing practices for refugee care. However, expert opinion and resources will lead the way for a "best practices" model for refugee and mental healthcare. These best practices will be shaped through the lens of artistic healing. Likewise, these practices will be able to be democratized in most any refugee setting if some of the basic guidelines and what we know about a universal humanity connection is present.

I.A Overview of the Refugee Experience Regarding Best Practices and Values

While we may tend to think of healing as it pertains to physical sickness or wounds, we must realize that much damage can happen to the human brain, spirit, and soul and that healing these aspects of an individual are as important as the physical ones. This type of healing must look to alternative practices. The reason for this is because in our very Western context of healing we often have a very systematic view as it relates to the "flow" of this care. Initially, one who has had damage done to the soul and mind may be interested in applying for insurance; they must look for a "good fit" in a psychologist or counselor. Western tactics are very credential-based. Individuals are encouraged to seek the "most qualified" or most trained physician. Artistic healing is not the only path to wellness in refugees, (and usually it is appropriate to seek other forms of help), but this paper will argue that it is the most available and most broad path of healing that is inclusive of all humankind.

I found myself in need of mental healing and healthcare in the spring of 2014. I continually found myself leaning over my kitchen sink, my fist clutching a knife, looking at my reflection in the mirror of the blade. The reflection that was staring back at me was a face that was empty, sad, helpless and hopeless. It was a face that belonged to a body that

had an un-well mind, heart and soul. As I stared at the knife I contemplated running it across my arms, hoping to end my life. This happened more than once. I found myself on Easter weekend staring at the knife when I should have been celebrating the resurrection of God's son. I should have been gorging myself with food I had given up for Lent. But instead I was still feeling the emptiness of the other thing I gave up for Lent, and for the 9 months that preceded it: my sanity. I was incredibly sick, so sick in fact that I wanted to end my own life. My days consisted of weeping and sleeping. I had lost all interest in my loved ones, hobbies and activities that usually brought me joy. I was a shell. I was a reversed ghost—the body here but the spirit removed. In an important book on the journey of life, author Parker Palmer (2000) wrote, "I understand why some depressed people kill themselves, they need the rest" (p. 58). Like Palmer suggested, I so wanted rest.

As I reflected back, (the beautiful gift that mental health care gave me), I realized there was a litany of things that had brought me to this very dark place. I have experienced everything from a home invasion, to car accidents, to family traumas. All of these experiences, "big" and small, left their emotional mark on me. Singular events can add up and play a horrific toll on our bodies and souls—and in my case, leading to a desire to sacrifice my own body in return for peace and rest.

During the summer of 2014 I spent 9 weeks at a psychiatric healthcare clinic in Houston, Texas where I was diagnosed and treated for Post Traumatic Stress Disorder, Major Depressive Disorder and traits of Obsessive Compulsive Disorder. My healing experience was incredibly holistic as doctors, therapists, my peers and staff all "worked on" my body, mind and soul. These three necessary components had to be addressed so that systemic problems and issues could be addressed. These components of everyone's life are

all very interconnected. As each week passed each of this wounded areas started to heal bit by bit. I realized that when I started taking care of my soul—my emotional self, other areas of my body and mind started to heal.

My story ends (or begins?) with hope. While my own personal plight can never be compared to that of refugees, as they are two very different experiences, I have had my own battle with mental health. What caused me to make this connection between my experiences and that of refugees was the realization that mental health care in the United States is a luxury. Many insurance plans do not include coverage for mental healthcare, and those that do those that do have high monthly rates, which is why it is primarily only accessible to the wealthy. Generally, insurance is only awarded to people living in the U.S. who are citizens and/or who have proper visas or IDs. For many of our brothers and sisters coming to the U.S. for asylum, these documents are nowhere to be found and it can take months, if not years, to secure them. Some refugees have no home country that is recognized by the United States. Implications of having no home country would put severe boundaries and limitations on receiving access to proper paperwork and identification resources.

One of the primary goals of this paper is to explore therapies that can be successful, relatable and helpful in refugee populations in the United States. I will also investigate holistic approaches concerned with artistic mediums that will bring healing to people who have suffered much, and who find themselves now living in a new culture and context. This paper will also explore how artistic therapy can help fight against negative side effects of trauma, but will also outline the he power that the arts can have to preserve one's home culture within a new cultural environment. Finally, this paper will explore how artistic

healing may help appease to social stigmas or cultural barriers found in refugee communities that keep individuals from seeking mental health care.

With appropriate therapy, refugees and other immigrants will learn to maintain their cultural identities and heal from their traumatic experiences. After traumatic experiences that refugees may encounter, such as not knowing when they are going to eat, witnessing war, extreme poverty, death and relocation it is easy for a person to lose their identity. People lose their identity, do not know where "home" is and their cultural identity is muddled. By healing the mind, body and soul through artistic healing, the essence of the individual's soul may be found anew.

Three major values that my artistic interventions will outline are: trust, community and healing. This paper will outline the trust and "adoption" of new family and friends that may be cultivated in artistic healing settings. Furthermore an overall sense of healing for the soul may be found in artistic healing interventions. Likewise trust in the future, in the people around you and your healing journey is also valued in this artistic frame of healing. Trust can be strengthened by artistic healing facilitators extending a culturally sensitive hand that point to instruction of practices *and* the absorption of new knowledge expressed and shared by participants.

While there are many forms of art, my research will involve specific forms of therapy surrounding the arts, particularly creative writing, production of artistic goods, and painting and drawing. I will address the importance of grief and going through a period of lamenting as it pertains to mental health care. I will include expert narrative and qualitative research to build a solid case for soul-care. Through research, my story and the voice of experts through text and interviews, I will outline that the current framework for

refugee care is not enough. The current care we have in place focuses heavily on tangible needs, and ignores mental well being or counseling and therapy that many refugees may need. Likewise certain Western approaches to healing such, as "talk" therapies are inadequate in reaching and healing our global brothers and sisters.

I.B Definition of Terms

In order to create mutual understanding, I will define commonly used terms and their definition below.

Soul Care: This is a type of care and healing that is aimed at a person's soul. Complete well-being includes the aspects of self that move beyond the physical body. Artistic healing interventions target an individual's soul.

Spirituality: Over the years there has been a shift in this definition from the religious to the secular (Swinton, 2001). It is often a hard term to define. However, in this paper, spirituality will refer to a concept that is not tied to religion, but rather a "multi-vocal concept" (Swinton, 2001) in which a person feels love, hope and other feelings and sensations that cannot be linked with scientific terminology. This type of spirituality is accessible to every human as we are all spiritual beings. It can be a sense of connectedness to the self, the world and a sense of purposefulness in life.

Artistic healing: Anyone can participate in artistic mediums for personal "therapy" or healing. However, when I use the term artistic healing in this paper, I am referring to facilitated groups where participants gather to express feelings and finding healing through artistic mediums. This type of artistic healing is structured and is led by a therapy facilitator, aid worker, development worker or licensed therapist. Artistic healing sessions that are referred to throughout include adult refugees or adult participants.

Bridge country: The country a refugee is sent to, or flees to, usually preceding the country that they will eventually emigrate to.

Resettlement: The process in which a refugee is moving and immigrating to a new permanent home country.

The Church: This term refers to the Body of Christ; the network of believers. This term does not tie itself to a certain denomination, but it also may include a physical space – "church" (not capitalized) where this network meets for ministry purposes and communal worship.

II. Gaps in Current Care

Current care for refugees in the United States is limited and can be intimidating and inaccessible. In an article researching paradigms of mental health care for refugees, author Charles Watters (2001) explained the progress of help and care that refugees receive during immigration. Watters (2001) is concerned that the mental health status of refugees is not adequately considered by their new host societies:

> Studies of the mental health of refugees have tended to emphasize the impact of past events, particularly those in the country of origin and in the process of flight, as the key factors in mental health problems. Scant attention is normally paid to the impact of post-migration experiences on mental health. (p. 1711)

Watters (2001) had major concerns that aid workers, therapists and development workers who are helping to assist refugees with proper mental healthcare are missing the mark. While consideration of past tragedies is vital for healing and necessary for moving on, Watters (2001) communicated that therapists and development workers need to explore

further. He claimed that this is vital for healing and necessary for "moving on", but many times that is where therapists and development workers stop. He also communicated that in order to set refugees or newly immigrated peoples up for success, therapeutic practices must include attention to behavior, hopes, dreams, joys, grief, challenges, and successes that are happening *now* in the refugee's life. Questions therapists must ask are: "What about your new home or community frustrates you? "What about it brings you joy?" "How can you make your life better *here*?" Therapy should look for ways of healing past traumas, but also must surround itself with the present. This "present-ness" can be established through artistic means. Writing, crafting, drawing or painting that reflects current emotions can evoke a sense of present life participation. Art is a type of free expression and it may take on the form the creator or author wishes it to be. The process of creative expression through the arts may causes people to become present and aware of themselves and those around them. Likewise it can give a much-needed voice to survivors of trauma and to refugees.

Creating a "voice" through therapy is a challenge because often refugees, when fleeing their country, are not initially placed into a permanent home country. Many times refugees wait for visas and paperwork for many months, if not years, before they move on to a more permanent home. Usually these "middle" or "bridge" countries, in many areas, are not ready for the influx of people. Generally refugees are unable to speak the language of their bridge country, doctors, social workers and other aid workers are scarce, lack training and resources are limited. An article that explored depression in women and therapy-based practices in rural Pakistan (Rahman, 2008) found that, although it is not

feasible for all aid workers to be thoroughly trained in psychiatric care, there are interventions that ordinary health workers could deliver with minimal training:

> The challenge is to adapt these interventions so that ordinary health workers can deliver them without previous training in mental health. Furthermore, policy makers in low-income countries need to be convinced of the public health importance of treating mental disorders so that they integrate such interventions into existing health systems. (p. 902)

Refugees living in their bridge countries need to be engaged and cared for. By using ordinary healthcare workers and developers who are familiar with psychiatric care, this transition can hopefully be the link to the care they need.

Scarce resources, and lack of significant medical education are not only found in rural Pakistan. In an article published by *The Journal of the American Medical Association* in 2003, authors and researchers compiled a research study surrounding mental healthcare in Uganda. For this study, World Vision (2003) took the first steps in helping supply therapists and anti-depressants. Many African countries have few or no national mental health care workers. For example, in Sierra Leone, in 2003, it was reported that there was only one psychiatrist for the whole country (JAMA 2003). These findings also showed that by implementing group therapy with Ugandan men and women, along with the administration of anti-depressants, participants scored better on depression surveys and other means of data collection (Bolton, 2003*)*. However, the article also revealed that *more* research, in multiple cultural settings, needed to be done to ensure that every culture receives the appropriate mental healthcare. Likewise, with refugees, and with art group

therapy, there must be more research and exploration with what works and what does not work in different refugee settings around the globe.

One research study conducted by cultural researcher and *New York Times* writer Tina Rosenberg (2014) on depression interventions in Africa found that worldwide mental health care is the *least* funded medical endeavor and cause in governments' health budgets. We must ask ourselves what the implications of this are for developers and those working with refugees. Not creating a pipeline of money for soul care and mental healthcare implies that the world, or at least political leaders, does not take seriously the effects of mental health. Likewise, it implies that as a whole, society has done little advocacy for awareness of mental healthcare, when so little money (if any), is being used for its campaign. If financial resources are not on the table (and will not cover professional medical training), what are ways healthcare advocates can make it more affordable? How can developers raise funds or conduct help and therapy that is inexpensive? Financial backing for research, medicine and doctors is nonexistent in many refugee communities, creating another hurdle international developers must jump as they find ways to reach these communities.

Not only are finances an issue for refugee care, but also preventative care is very limited. An article written by Stephan Weine, M.D (2011) explored the importance of creating preventative mental health interventions that would help and address the mental state of refugees who are resettling into the United States. Doctor Weine (2011) communicated that if refugees are able to attend therapy and group counseling in their initial immigration process, they will be far better off, mentally, emotionally, and physically than refugees who do not receive mental health care. However, there are many barriers that come from within a refugee community that may keep patients form coming forward

to receive care. Doctor Weine (2011) expressed that many individuals face obstacles such as "social stigma, lack of services, access problems, and cultural barriers" (p. 411). As we think of therapies for refugees, these obstacles must be taken into consideration when setting up successful models and interventions. Furthermore, medical doctors Ramin Asgary and Nora Segar (2011), who researched barriers to health care access for refugee populations in New York, found that many refugees did not even answer or identify psychiatric symptoms on medical evaluations or surveys. The issues simply were not important enough to the refugee to note, the refugee did not understand the questions due to language barriers, or the refugee felt that there were more pressing issues at hand. Additionally, "mental healthcare" and other terminology may not even be on a refugee's social or culture radar.

According to an essay published by the *Canadian Journal of Public Health* in 2008, approaching or finding any type of medical attention or help is sometimes out of the question completely for refugees. Many times if a refugee has a condition such as HIV, that preceded his moving to a new country or bridge country, the fear of being deported is very high. This results in missed clinic appointment, health screenings, and follows up. Also many physical and mental health clinics will not see patients without proper identification. Many refugees go months and sometime years without current or proper identification. A huge challenge for aid workers in Canada is processing forms of identification while trying to diminish refugee's fears of seeking help.

III. Mental Health Care: An Inherent Right

Having grown up in a very conservative Christian setting, I can distinctly remember a sermon on depression and mental health disorders and hearing that, if an individual was

depressed, it was because of his or her own sin or some deep-rooted secret that needed to be confessed. This section of research will examine scripture, particularly Lamentations, and note the importance of having seasons of rest, reflection and grief. Additionally this section will explore spirituality and depression and what the implications are for a Christian developer working with a refugee population or individual. Likewise, cultural religious implications of mental health disorders will be addressed. While Christianity has its own social stigma concerning mental health, other religions have similar opposition regarding this type of sickness.

In the book *Spirituality and Mental Health Care: Rediscovering a Hidden Dimension,* author John Swinton (2001) pointed out the Christian denominations can in fact improve mental healthcare. For example, people find a network of support in a church body. People suffering from mental healthcare may find a framework in which to live their lives and a moral fabric that they wish to implement into their lives. A religious belief system may also help provide new avenues of coping during distress (Swinton, 2001).

However Swinton (2001) also addressed the damage that religious communities can do to those who struggle with mental illness. Religious communities can isolate. The Church can be a place of judgment, or merely a "band-aid" to deeper problems. Some religious belief systems ask their followers to refrain from using medication. Swinton (2001) explained that as developers, counselors and aid workers, we may live in the tension of the positive and negative that organized religion can bring. This tension is magnified when it concerns refugees. Historically, refugees have been the "prey" for religious organizations. Likewise, in some communities mental health is deeply entwined with religious beliefs. According to Ambassador, who became a U.S. citizen this past year,

many communities in his home country of Ethiopia believe that mental health symptoms are often thought to come from demon possession or other spiritual phenomenon. (A. Halefom, personal communication, February 2015). The Christian church in Ethiopia regularly ostracizes, exploits and sometimes even abuses individuals showing severe signs of mental distress. Christianity and other religions have thought that by reaching people through conversion and proselytizing, that refugees may have an easier time adjusting to their lives in a Western context. This approach is not only damaging to a refugee's well being, but it is also highly insensitive to cultural religious and spiritual beliefs and practices.

Cultural or religious adjustment can be aided through practices that may seem to transcend location origin. An example of an "Eastern" practice that has been adopted by the Western culture is Mindfulness; if we take this practice deeper we have a practice referred to as Mindfulness Meditation. Mindfulness has been proven effective in anxiety reduction and lowering psychological distress among therapy participants *and* practitioners by increasing empathy and compassion. Mindfulness is connected with Buddhism, and it a key discipline that many followers of Buddhism, are encouraged to practice. It is defined as the idea of being and feeling in the moment without judgment; it is something that can be practiced and learned over time. In an article by Goodman, & Calderon (2012), the authors explored how mindfulness can help create new neural pathways to the brain. Post Traumatic Stress Disorder, one of the most common diagnoses after experiencing trauma, causes the amygdala (the reptile fight or flight center of our brain), to be constantly turned on. Mindfulness administered and taught during therapy with patients experiencing PTSD can prove very successful in creating new responses in the brain, and in causing new neurological pathways to the logical part of the brain to be formed and readily accessed.

Thus, mindfulness can literally reformat and heal the brain. Mindfulness alone can draw people into the present. Furthermore Christian developers may consider this to be something that they incorporate into their best practices. Mindfulness is also supported in scripture. In the book of Psalms it is written: "My mouth shall speak wisdom, and the meditations of my heart shall be understanding" (Chapter 49). Verses in the Bible ask us to "be still" and to still our minds. The New Testament asks us in 2nd Corinthians 5:10 to "take every thought captive"—verses continually, throughout scripture, point to a position of mindfulness. Mindfulness not only keeps individuals from a dark mental space and spiral downward, but it also allows them to care, to listen to others, and work more effectively by brining the self into the present. Therapist Dr. Deborah Haines once told me [personal communication, February 14, 2013], that the Bible from front to back, points us to mindfulness and engaging in the present—what is actually happening. She reminded me that God does not claim that "he was", or that "he is going to be". Rather, in Exodus, God proclaims to Moses " I AM". He is ever present and constant. This key step and practice to healing is not just found in certain religious arenas, but is also a universal truth and guide. Christian developers may push an Evangelistic agenda (religious conversion), into mental health care, but practices such as mindfulness should be considered a universal spiritual capacity, thereby shedding the notion that it must be tied to a particular denomination or way of religious thought.

III.A Spirituality, Christianity and Diagnosis Implications for the Global Developer

We cannot discuss social justice for refugees without mentioning inherent rights. This is the idea that simply by being put on this earth, humans are given a set of rights that are given to them by God, or by some other higher force or power. Some examples of rights

would be food, water, and shelter. To others, education, health care (including mental healthcare), and family or a sense of belonging are also included in the list of basic human rights. Nicholas Wolterstorff (2008) wrote about inherent rights as "justice as inherent right" (p. 11). Though we know that there are many populations and communities worldwide who experience the injustice of the healthcare system, developers must remember that justice should be available to everyone in all components of life. Furthermore, aid workers and developers must do whatever is in their power to bring justice as an inherent right to the forefront of their work—specifically the forefront of mental healthcare for refugees. Likewise, these developers and healthcare workers must address Western diagnosis in a multicultural context.

III.B Post traumatic stress disorder and other trauma related diagnosis

A common diagnosis for people who have experienced trauma is Post Traumatic Stress Disorder. Dr. Allen (2005) the director of the Menninger Institute in Houston, Texas defines PTSD as a mental health disorder triggered by a terrifying or frightening event. A PTSD diagnosis can come with a list of problems and side effects that varies from patient to patient. The Mayo Clinic's categorical symptoms of PTSD are:

Intrusive Memories	Avoidance	Negative Changes in Thinking and Mood	Changes in Emotional Reactions
Upsetting, recurrent memories of traumatic events	Trying to avoid thinking or talking about the traumatic event	Negative feelings towards other or yourself	Outburst of aggressive behavior
Reliving traumatic events (flashbacks)	Avoiding places, activities or people that remind you of traumatic event	An inability to experience positive emotions	Continually heightened adrenaline

Upsetting dreams about past trauma		Feeling emotionally numb	An overwhelming sense of guilt and shame
Severe emotional distress or physical reactions to something that reminds you of the trauma		Lack of interest in activities you once enjoyed; lack of interest in people and close relationships	Self -destructing behavior i.e. drinking too much, driving too fast, or self harm
		Hopeless about the future	Trouble sleeping and trouble concentrating
		Memory problems, including not remembering aspects of traumatic events	Being easily frightened, startled or panicked

(Table 1)

In an article discussing PTSD, Jobson (2008) examined the effects that culture has on people when it comes to identity formation when suffering from PTSD. Generally, thoughts and actions become unclear, a person is revisited by traumatic memories over and over, or the opposite occurs, and the individual become increasingly numb to every life event. Sufferers of PTSD may also experience severe mood swings and heightened emotional reactions to everyday events. These symptoms, I would establish, are universal.

III.C Depression

While this diagnosis might seem more obvious to some, others may believe that depression is a first world problem and that only the Western world struggles with this type of illness. However, Rosenberg (2014) believes that depression and other mental health disorders are universal. The quality of life that many refugees have escaped is quite bleak, and their situation in the United States can be equally bleak for different reasons.

This is a type of mental adjustment that we may need to make when we think about refugees in the United States. We often have the mentality that refugees are the ones who need to make the adjustments, and that now that they are in America they must be so happy and relieved. Generally the reality is quite the contrary. In a documentary film created by anthropologist Taggart Siegal (1984), about the Hmong people who moved to the United States in the late 80s and early 90s, we are given a very vivid picture on the stressors, heartache and trauma that the Hmong people experienced in America. Culture shock, language barriers, religious practices being judged or frowned upon, the trauma of recent events in their home country, the trauma of not having a "home," and poverty all make for a very poor quality of life, even in the "Land of the Free". This depression can be quite crippling, and is the thief of a productive life in women around the world, and the second highest cause, for men (Rosenberg, 2014).

III.D Are Western Diagnoses Applicable on a Global Scale?

In his book, Watters (2010) provided readers a global view on how Western mental healthcare has influenced other countries around the world and how these global neighbors perceive their own psychological identity. Although Watters (2010) expressed that Western healthcare workers have annihilated traditional and indigenous response to mental crises and he occasionally flirts with conspiracy theories, he did make some very important points. First, Watters (2010) pointed out that terms I have used above, such as depression and PTSD, are Western in nature. These diagnoses generally do not even have an equivalent word found in languages around the world. Watters (2010) asked healthcare workers to consider how mental healthcare workers could label someone's mental state, when the word for that condition or diagnosis is not even found in the patient's language?

Additionally, Watters (2010) examined in extreme detail the effects health workers had on areas affected by the tsunami in Sri Lanka. He described a very chaotic scene in which hundreds of mental health professionals flooded Sri Lanka and neighboring areas offering their best medical advice and expertise. Watters stated, "It takes a willful blindness to believe that other cultures lack a meaningful framework for understanding the human response to trauma" (p. 107). Watters (2010) expressed that Western healthcare workers have worsened the situation. The projection of Western labels onto refugees is damaging, and does not reflect the position of learner or student. Watters (2010) expressed, "Some trauma counselors in Sri Lanka all but ignored local customs and practices and stridently asserted that they knew better than the locals how to handle the psychological aftermath of the disaster" (p. 98). Instead of taking notes and lessons and giving the "traumatized" a voice, Western "experts" began administering their therapies *and* started teaching those practices to those who did not share their common language. In this particular example, practitioners even taught young children how to look for and diagnose individuals with trauma related symptoms. While we see gaping holes in this type of care in an international setting, Watters (2010) also criticized the practice of trauma counselors in the United States. He recounted the story of the United States facing two natural disasters, a hurricane and an earthquake, happening weeks apart on the two coasts. During this time, trauma counselors left one area to go help another. The abandoned community was left with minimal resources. Westerners also suggested that individuals living in Sri Lanka (or other cultures who have experienced great loss and pain again and again) have experienced trauma and crisis so many times, that they have a resilient attitude and can handle the mental burden (pp. 86-96). I have personal examples of observing people hurt and heal

from trauma. A friend in Singapore who had survived the tsunami in Phuket, Thailand shared with me that she struggled with anxiety, fear and other psychological demons after surviving the tragedy [personal communication, March 2012]. Furthermore, contact whose grandparents were Russian Jewish refugees during World War II showed side affects of trauma, such a depressions and anxiety, long after the war had ended. I have encountered individuals who have lost friends and family in multicultural settings whose lives have been immersed in grief, bodies have been burdened by sleepless nights and other physical hurdles. After reading, interviewing and researching, I have come to one conclusion: that signs and evidence of trauma are universal. Even if someone shows resilience in life, or in a counseling session and seem to be "fine" to the outside world, repressed feelings and emotions will manifest themselves "sideways" (in unhealthy ways), in relationships, personal fears and anxiety, avoidance, or if the trauma too severe and too repressed, complete psychological breakdowns.

A story that gives support to the idea of universal trauma symptoms comes out of India. Jeremy Vallerand, the founder of an anti-sex trafficking nonprofit called, Rescue Freedom, told the story of a young girl who had been rescued from sex trafficking in India. This child had been so severely traumatized by rape, abandonment and fear that she was in a catatonic depressive state, after her rescue. Fortunately after much love, therapy and other healing practices, this young girl made psychological strides and began to speak, move and play again [J. Vallerand, personal communication, October 2013]. A common phrase I heard one evening in Health, Healing and Culture Class, during a panel discussion with health workers from Lutheran Counseling Network, was "resilience". The two women who served as counselors at LCN, Christie Schmid and Khawala Adi shared with our class

that they have seen refugee patients come in and show great strides and healing that has already taken place in the individual. They are "resilient" and though they have seen and experienced tragic and traumatizing events, for the most part, they are unscathed [C. Schimd and K. Adi, personally communication, March 3, 2015]. Again, this is where we must question the legitimacy of this "resilience". Trauma and affects of trauma are more universally found, according to the research. To claim someone is "resilient" and are almost completely healed, is misleading. Talk therapy or more Western types of engagement may not always the best methods to evoke a refugee's emotional core. Through engaging in artistic expression and healing practices, untapped emotions and places of "sickness" will be made more available to the mental health worker.

Dr. Sherman (2010) communicated with me his rebuttal to Watters' (2010) take on trauma and stress. Dr. Sherman expressed that many people might show physical signs of stress and anxiety from trauma through psychosomatic symptoms. However, he stated: "People who live in hyper vigilant states can create a new baseline and can be brought down to where it doesn't cause as much stress on the body" [J. Sherman, personal communication, February 11th, 2015]. For some, Dr. Sherman continued, that baseline is high. Those who have been exposed to trauma again and again and again might be able to deal and cope with things in a less exaggerated manner and response, due to the fact that their amygdula or the "reptile" brain is already activated. Likewise, a person who has never experienced trauma, for example a person who was living a normal life and then was uprooted and became a refugee, might have a different response.

III.E Christianity and Mental Healthcare

Earlier, this essay suggests, that at times Christianity may not accept depression as a mental health diagnosis. Furthermore there has been some thought on the benefits of a spiritual sense for one's mental health. During my healing journey at the Menninger Clinic in Houston, there were many pillars of our wellbeing that we (patients), were to focus on as part of our wellness plans. One of these areas was spirituality. An article written by nurse Mary Linda O'Reilly (2004), who has extensive work years in the mental health care field, noted:

> Spirituality can support healing and wholeness in the face of emotional distress. Among hospice patients, spirituality was a healing force when it was expressed as the discovery of the true self through caring relationships, in giving thanks, and by embracing grace. Higher levels of spirituality were associated with lower levels of anxiety, as well as lower risk of suicide and substance abuse. Twelve step programs encourage the conceptualization of a higher power not as a religious construct but rather as a source of strength and guidance, helping those in recovery accept themselves in a spirit of self-love and forgiveness. (p. 4)

Elements of someone's spiritual life, when it seems off balance, thwarted or challenged, can cause great mental distress. However this type of distress has anything to do with one's (in the Christian context) devotion or growth in Christ. For example, many people throughout history who have been followers of Christ have struggled with depression; Mother Teresa, King David, and Saint Paul to name a few. They were steadfast in their devotion to Christ and at many times documented in writing the struggles with the dark night of the soul. However no one would accuse these three individuals of removing God from the bigger picture of their work.

O'Reilly (2004) suggested that, when practitioners or health workers start to point the finger of blame on someone's spiritual life, the risk of coercion, manipulated conversion or counter transference may be present (p. 7). She suggested that health workers and mental health care advocates should take a neutral stance to avoid biased assessment of artistic healing or other healing modalities in patients. However spiritual assessment should not be left out of assessment tools or other resources. It is important to get a grasp on someone's spiritual worldview, but it is also imperative, according to O'Reilly (2004), that "tools used in spiritual assessment must be unobtrusive and nonjudgmental, adaptable to client context and need, and worded so as to encourage participation and convey respect" (p 5). Gaining knowledge of a refugee's spiritual background is critical, but the facilitator of artistic, or any other healing modality, must remain spiritually neutral.

III. How Artistic Healing Increases Well-Being

In an article by Geoff Lowe (2006), a clinical psychologist who has worked with re-settled people and people groups, he found that there is solid evidence that people who engage in creative writing practices feel healthier and happier after participating. Additionally, we find in Lowe's (2006) research that there are chemical changes in the blood that boost the immune system. This chemical change can be a slower process for those who tend to write about trauma, but after time the immune system is still stronger. Lastly, in those who participated in creative writing, Lowe (2006) found that health was enhanced in four outcome reports: reported physical health, psychological health and well-being, physiological functioning, and general functioning.

The reason PTSD survivors can report improved physical health after writing is that their somatic issues lesson. This is a phenomenon that happens to many people who

experience PTSD. Somatic issues concern the way the body reacts to trauma. In one work, psychologist Rene St. Jacques, (2014) described somatic consequences as:

> The fields of Interpersonal Neurobiology, Somatic Experiencing, and Neuroscience are pertinent to this discussion as they offer a wealth of knowledge about the constellation of physical symptoms resulting from the body's attempt to process trauma, mild or severe, for which many relative treatments exist. For instance, consider medically treating the person's bodily symptoms, or treating only pathologies such as anxiety and PTSD through mental health interventions, or treating both. (p. 47)

St. Jacques (2014) went on to say that through her research she has learned that trauma does indeed affect both the physical and the mental health of any trauma survivor. Implications of these somatic issues, she suggested, are that caretakers of trauma survivors must use holistic treatment to help heal the survivors' trauma-induced mind and body illness. If this were not addressed as a multi-part healing, a cycle of trauma or being traumatized would continue.

In many instances, people may not recognize somatic issues in their bodies. Many write it off and point to other reasons and causes behind their physical distress. Some believe that there is little connection between mind and body, and that many physical aches and chronic pain is in no way linked to the emotional body and mind. However, not only are we humans susceptible to physical side effects, but Christ, while on Earth, even experienced somatic side effects. A Biblical example of somatic symptoms affecting Christ can be found in the gospels. Luke 22:44 stated, "He prayed more fervently, and he was in such agony of spirit that his sweat fell to the ground like great drops of blood." Even Christ,

God in the flesh and a divine being, experienced biological disruptions due to the stress and knowledge of what was about to take place. Our bodies, like Christ's, are very much affected when we are internally and psychologically distressed or traumatized.

One of these symptoms can include the perception of self to be muddled. In a case study, Tan (2012) described the success of holistic treatment through art. In the context of Cambodian artistic healing groups (specifically writing and personal journal entries), she communicated the wonderful awakening and healing that artistic healing has brought to the most broken girls in Southeast Asia. Many of these girls are undocumented immigrants or come from varying cultures in Cambodia. Tan (2012) referred to this as a type of "creative healing" process. She noted that many, if not all the women were able to gain a new view on their lives through the group therapy and establishment of a safe and non-judgmental space. This new perspective caused them to believe that hope, healing and health could occur organically and systemically. Many of the participating women reported that they felt very happy and co-empowered through the creative process.

IV. A Tools to Help Us: Ethnography in Art Healing

Cultural researcher Elzbieta Gozdziak (2004) argued that more traditional Western psychological and psychiatric approaches are never appropriate in the context of most refugees i.e. talk therapy, psychoanalysis. She suggested that as medical professionals or aid workers, when we walk into a situation where someone needs help, the best thing is to be a learner; we must become students of the culture and first seek to understand before we can help. Gozdziak (2004) recommended that we become students and learners of the culture. We must perceive trauma, hurt, tragedy and disease through multiple cultural lenses. This will allow developers and physicians to move away from such a limited and

narrow scope of evaluation and diagnosis. Physicians would be free to explore trauma, healing, and therapy at it relates culture and social aspects in a refugee community.

Artistic healing may be able to address many of the above challenges, without being inaccessible. Artistic healing practices do not have to be expensive. Through interviews and research, it has been found that many times artistic healing sessions require very few items and resources, causing the cost to be low. However, this does not include salary or payment for the facilitator. Furthermore, artistic healing sessions may establish a safe space for vulnerability and open sharing through art mediums. Participants can be encouraged to share past traumas and current fears and anxieties. Also, the facilitator or therapist can be a resource of additional healthcare.

According to the American Art Therapy Association (2014), artistic expression as it pertains to healing and counseling, was formally established in the 1940s. Therapists during this time started noticing that artistic expression proved to be a sound form of communication, especially in young children, who did not yet posses the verbal capacity of an adult. We can envision the benefits and positive results this can yield in a refugee setting. Art can be used just as Gozdziak (2004) hoped all multi cultural and refugee therapy would be—as a link to successful multicultural practices in health care. Furthermore, artistic healing practices will certainly be useful when participants and health workers find communication to one another difficult. A picture, drawing or painting could be more communicative and truer to the participants' feelings.

The above ideas can be tied to Biblical principles and is justified through scripture. As developers and therapists who seek to serve, to listen and to be taught, we are exemplifying the truth and model of Christ. In his letter to the Corinthians, Chapter 2, Paul

wrote, "he made himself nothing, taking the very nature of a servant being made in human likeness. And who being found in appearance as a man, humbled himself". In Proverbs 9, it is written, " A wise man will hear and increase learning." Through artistic healing, the therapists and social workers are the learners.

IV.B Successful Module for Artistic Healing

I had the great fortune of being able to interview a woman in Turkey who is currently doing artistic healing work with refugees in Istanbul. I will address my friend as Leyla, a Turkish national who was able to share with me the module that she uses for her therapy practices. Leyla studied Art Therapy in the United States and Sociology in Turkey. Currently, she works with a faith-based organization that partners with refugee agencies. These partnerships allow Leyla to go into refugee camps or cities with high refugee populations.

During her sessions, Leyla works with groups of 6-8 adults and sometimes with families. These groups meet for a week for 2-3 hours per day and are void of any type of Western psychological label i.e. depression, PTSD, mental health care. Hannah shared with me that she has a list of objectives. First, Leyla wants participants to leave with a better sense of self-esteem after her therapy sessions. Secondly, her hope is that participants will feel that the therapy space is safe, that participants will know they are free to share and that there is safety in the group. The target and main objective Leyla has for her artistic healing group is building trust. Trust is very scarce in refugee communities. Leyla's hope is that the community and trust that is created in her therapy session will extend into the outside world.

Some of the greatest successes, according to Leyla, and the most beautiful stories she shared with me, were those of the creation of an adoptive family. This is not a typical adoption in the sense of a mom and dad adopting a small child or infant. Rather, this adoption came about when refugees brought lost, struggling or hurt people under their wing. People filled roles of family in others' lives. . Mothers who attend Leyla's artistic healing session find orphaned or abandoned children and have become surrogate mothers to them. Couples who have lost children in their upheaval befriend other couples who have also lost children. New family is created. There were other stories of fathers who had lost their sons due to war or disease and who are now mentoring and "taking in" other young men without fathers or family. Young women have connected with other young women and have become sisters. All of these are beautiful stories of trust being birthed anew. These types of stories are especially important, according to Dr. Weine (2011), a specialist in mental health care and refugees. The health of a family's relationships during resettlement, and thus the mental health of each family member, has very much to do with family dynamics and support. Because many refugees have their entire family in tow during resettlement, creating an extended family and a place of trust is vital and seen as a preventative step to great mental healthcare problems down the road.

IV.C Personal Narrative and Creative Writing

Gail Kretchmer, an author who has her Master's Degree in Creative Writing, described to me the writing workshops that she has held for women who were battling cancer and for women who had left abusive situations. Both sets of women were facing their own traumas and experiences. As Gail has led and facilitated many of these sessions for women spanning across the Pacific Northwest, she found that a common theme in every

class, not dependant on participants or locations was, confidence. The women in Gail's writing workshops included cancer patients who were often bald, thin, weak, and some even close to death. Others had nearly escaped death and were living in a place of fear that the cancer would return. These experiences had resulted in a very low level of self-confidence among participants. In the domestic violence groups, women were incredibly quiet at first, did not make much eye contact with Gail, and many of them did not volunteer to share what they had written. Gail brings to her workshops prompts like: "Write about a vacation you took as a child"; sometimes she has participants write poetry, or about an array of topics. Gail communicated that the topic did not always matter, but the mastering of writing something, the accomplishment of creation and confidence in sharing made these women's backbones stand taller, their faces glow and their voices firm. I could picture these workshops in my head. As time would go on, Gail explained to me that she would have more and more volunteers to read, and that the women would seem to be more comfortable in the space she had created, establishing a newfound ownership of confidence [G. Kretchmer, personal communication, August 2014).

In an article by the *New York Times* that centers on a Duke University study pertaining to writing and health, author Tara Parker-Pope (2015) wrote:

> The concept is based on the idea that we all have a personal narrative that shapes our view of the world and ourselves. But sometimes our inner voice doesn't get it completely right. Some researchers believe that by writing and then editing our own stories, we can change our perceptions of ourselves and identify obstacles that stand in the way of better health. (2015)

Parker-Pope goes on to share that the study put on by Duke University took two groups of students, a control group and an intervention group. The intervention group was asked to write a narrative about their ability and their self-confidence; most students wrote negatively about themselves and believed they lacked the confidence to continue in school. However, after watching videos and being exposed to other "positive" experiences that explained that it was normal for freshman to struggle in school and normal for students in general to feel like they would not finish, but then to find the inner strength and self-discipline to do so, the students were able to re-write their personal narratives about school. Almost all of the students changed their opinions of themselves. The writings reflected self-confidence. Students who had been prompted to change their personal narratives improved their GPA and were less likely to drop out over the next year than the students in the control group. Participants in the control group, who received no positive advice, saw 20 percent of their group drop out of school within the school year. The intervention group saw only a 5 percent drop (Parker-Pope 2015).

The above supports an argument for why writing could be an effective way to aid in a refugee's healing process. Even thought the Duke study includes high-risk students, and not a refugee population, the principles can remain the same. If you took a group of refugees and placed them into an artistic healing group and had them write their personal narratives based on directed prompts, then introduced a speaker or testimony from a refugee who stated they had the same feelings when they first moved to their new home country there could be a sense of kindred-ness. Hypothetically, when they are asked to re-write their narrative the hope would be that they would be able to remember the encouragement they had just heard and experienced. Reading out loud and group sharing

of their writing can also be beneficial for self-confidence. Furthermore, the ground rules for no judgment and expected outcomes would need to be laid as to create a gentle and comfortable process.

There has been some pushback against this notion of creative writing and writing in refugee artistic healing groups. Many outsiders have had concerns about the language barriers. Would writing be able to be democratized? The answer in the context of American refugees is a resounding yes. Not only will refugees living in the United States most likely be involved in an ESL class, but also it will be necessary (out of personal ambition or simply the demands of life), to learn English. If that is not a viable option, Seattle and most major U.S. Cities have many vast and growing cultures represented in their respective areas. Somali refugees for example, could have a writing workshop that included a Somali facilitator. Leadership and outside resources do not have to be left to the "white" or "western" English speaking person; yet, that may have benefits as well. Not only would writing workshops or therapy prove useful for developing English skills, but the experience could also create new community and a chance to learn about others' experiences, a chance for bonds to be made, and a chance for *confidence* to be built.

IV.D Creative and Artistic Tasks and Production

In an additional conversation, Dr. Sherman expressed another art experience that he has seen beneficial to communities of refugees. Dr. Sherman shared that, "in some refugee communities, women from certain cultures can benefit from producing something". He went on to suggest that group work, especially for women, be it beading, knitting, or producing something, "promotes self-esteem and an environment of sharing and healing." This is a beautiful insight. In many cultures, women share daily experiences such as

childcare, fetching water, preparing meals, with other women. If there was a creative space for female refugees to have this group and shared work, not only would it bring a piece of "home" that is perhaps missing in their new home, but also creates a place for personal growth, asset building, development and shared healing (J. Sherman, personal communication, February 11, 2015).

V Democratizing the Art Experience

Types of artistic expression must be accessible and relatable to the people who are participating in artistic healing. A way to do this is for facilitators to use writing prompts that are tailored to the culture and abilities of art healing practices are relevant to cultures in a myriad of refugee settings. Often times when we think about the word "therapy" we are confronted with a complex system of cognitive and talk therapy practices that are implemented and practiced by a patient in order to relieve stress. However, a phrase taken from the U.S.'s artistic healing mission statement is that artistic healing is the creative processes to help people of all ages improve their health and emotional well being (2014). As humans, whether we know or realize it or not, we are creative beings. This is reflected in the Bible from Genesis when Adam names the animals, to David in 2nd Samuel dancing in the streets to John interpreting visions in revelation with such detail, artistic and visual elements.

Additionally, not everyone in refugee artistic healing groups will be on the same page when it comes to education. Some participants may currently be in school and some may have degrees from their former home countries. Some participants may have lived in a refugee camp during their primary school years. A practice mentioned by Don L. Jones (2000) suggested that not only can developers use and encompass the actual creation of art,

but also studying and examining pieces of artwork can be a catalyst for group discussion and emotional sharing. What does a certain piece of art mean to you? How does it speak to you? When we look at this painting what do you feel? What is this sculpture or drawing saying to you? These are all questions we can incorporate into an artistic healing session. No matter the cultural backgrounds or education levels, participants may be able to share their own opinions and insight. They will bring new thoughts to the table based on their personal lenses. Bringing an art piece into a session that is culturally relevant to the participants may also be a comforting factor or in a way, a cultural link and preservation method with ties to their old home. However, a facilitator must be prepared to address uncomfortable feelings it may bring to the room. If this is the case, and if the group seems mixed it may be even more appropriate to ask the individuals to bring in their own pictures, stories or personal objects to describe, write about, paint or recite. Artistic healing through these measures may evoke all sorts of emotions.

In an article examining loss and grief, David Charles Hardy (2013), shared how artistic expression can help achieve a sense of present-ness, mindfulness and belongingness to patients suffering from severe loss. The author shared the story of one of his clients:

> Immersed in her thoughts, Sandra appeared for a while to forget her surroundings as, paint brush in hand, she began to roam across the page. The staccato marks she made seemed to echo the breathlessness in her voice, the vividness of the colors something of the intensity of the moment, the physicality of the day. Attuned as she was to the sensations of touch, smell, sight and sound, Sandra appeared in this session to have a heightened sense

> of both being and belonging, as she lost herself in her pictures and her thoughts. (p. 33)

Artistic healing brought Hardy's patient, Sandra, into the present. Sandra, who had once been "distant" and dissociative, was now able to experience sensations that matched how she was feeling internally. This connects to ideas concerning somatic issues and mental health-- the idea that our bodies and minds are connected in a very intimate way. In the above example Sandra's newfound sense of expression could make her bodily feelings, hurts, pains and joys manifest through the mediums of canvas and watercolors.

Through the research and interviews included in this paper, I have concluded that artistic healing is the least intimidating form of therapy for refugees. Discussion and participation surrounding artistic healing is usually far less intimidating than lying on a therapist's couch, or taking pills that are foreign to one's culture and body. Additionally, art forms are generally universal and can initially evoke a sense of community. Nurse O'Reilly (2004) wrote:

> Appropriate interventions directed toward multiple dimensions of the human experience are essential to healing and to the development of hope through connectedness with other people and the universalities of life. (p. 8)

The potential artistic capabilities that are in each human being is a dimension of the human experience that must be taken into account by mental healthcare professionals when working with refugees. Then a connectedness and a universal language can be shared and understood.

<u>V.A Program Evaluation</u>

How do we know if this is working? What are signs of a successful artistic healing

group? According to Leyla my contact in Turkey, and Gail, my friend in Seattle, the core for success in artistic healing practices is the trust built through participants' intimacy and vulnerability and thus the support that ensues. The main benchmarks artistic healing can achieve are the increase of comfort, intimacy and vulnerability that comes with relationships. To measure this success, facilitators of these art groups may find it necessary for pre and post "tests" (in our case artistic therapy sessions). Surveys or oral interviews could be appropriate. Pre tests could gather information that could inform the facilitator of the needs of their refugee group. According to *Outcomes for Success* (2000), "an organization must envision the expected impacts of the program on its participants" (p. 14). Facilitators may ask participants questions surrounding friendships and how they would define the trust they have built between their peers. Evaluation can be executed in a number of ways; however, it is imperative if the facilitator wants the program to grow and to serve the needs participants have. Furthermore, since narrative expression is shown to decrease anxiety and depression, improve immune systems, and so on, surveys could ask participants to rate how these somatic symptoms are after the workshop. But in all honesty, the more marginalized

Likewise, assessing the development of hope is essential in artistic healing settings. Though we find it hard to measure things like hope, love or other emotions, there can be concrete outcomes to aim for. For example, "Artistic healing increases the feelings of hope in refugee participants", or "Artistic healing groups decrease a person's sense of hopelessness". These benchmarks would need to be put into place, but through interviews, surveys, pre and posttests an evaluator would indeed be able to assess hope development and growth.

Many times, according to Paula Rowland, an evaluation expert, non- profit or social service work does not allow program evaluation and outcomes to work *for* or in their favor. (P. Rowland, personal communication, February 2015). Many times organizations may become scared that the consequences of program evaluation could cut funding or support for such programs. However, Rowland (2015) communicates over and over again that evaluation can be a positive tool that will only reinforce the good and the realm of positive impact an organization can achieve.

V.B Globalization and Artistic Healing

Globalization, or the process of the world getting smaller and smaller, is an important piece of the immigrant puzzle. Globalization has helped alleviate poverty worldwide; it has brought advancements in global communication through the Internet and other electronic means and has created more opportunities for employment and higher education. However, we *must* admit that with globalization comes a demolishing, and endangerment of certain cultures, cultural norms and practices. It seems that some cultures are endangered as a result of living in a globalized world. Likewise, refugee cultures are endangered when shifting to a new cultural context--generally a Western context. Another layer is that for many refugees, immigrating into a Western context generally is preceded by a stop in another country while their new "home" sorts out paperwork, immigration quotas and logistics for immigration. A question we must all answer is," can we reconcile this idea? Is it ok that certain ways of life are now obsolete if it means that more people are being brought out of poverty and into what could be a better life? The author, globalization expert and guru Thomas Friedman (2005) would say yes. Friedman (2005) compares the pace at which the world is experiencing globalization to

that of a heard of animals. While Friedman (2005) expressed that the movement of the "electronic herd" was and is inevitable, developers and aid workers must realize that there is a sacrifice of culture, traditions and social customs that come along with this. Once a culture, country, or people become deeply embedded in globalization through immigration, it is hard and sometimes impossible to turn back. While I do not know if there is a right or wrong answer to this, it is something we have to face. A good aid worker, development worker, or artistic healing advocate will realize this phenomenon, try their best to face it and be sensitive to how it is affecting the core of the people they are working with. We Westerners have done a good job annihilating civilizations and cultures: Native Americans, Hawaiians, and African-American slaves to name a few. Even the best aid workers who have the best intentions might not know what to do when faced with a culture different than theirs. We must look to refugee participants to guide the way in the implementation of their cultural ways and practices.

When advocating and executing artistic healing we realize there are many different forms and means in which to deliver this practice. How can art help preserve a culture? Or, at the very least, how can it bring pieces of a "lost" culture into a new cultural context? A recommendation for artistic therapy groups would be to ask participants to draw upon what they already know. What are images or stories or songs that remind them of home? What are the messages in these mediums? Is there a way to grasp onto culture and bring it with you to your new home? Does more than one person in the group share their similar stories, songs, and experiences? All these ideas and memories attached to artistic expression can help create and establish a "new" culture-- one that is not completely void of the old, but one that is adaptable to their journey. Furthermore incorporating the culture

into art healing practices will prove to be a best practice. The aid worker and developer must value and respect participants' cultures and cultural needs.

V.C Seattle Area Refugees and Mental Health Care

Alyssa Van Hofwegen serves as the Health and Educations Programs Coordinator at World Relief Seattle. Her job is to connect refugees to affordable health insurance, and she also assists in helping families with children's educational barriers they may encounter during their relocation process. Alyssa communicated that generally when refugees seek services at World Relief, a caseworker helps sign them up for Medicaid. (A. Van Hofwegen, personal communication, December 15,2015) Alyssa and caseworkers also introduce refugees to the healthcare programs that are offered outside the umbrella of Seattle's World Relief chapter. The primary place that Alyssa refers refugees is the International Counseling and Community Services (ICCS), a service that falls under the umbrella of the local Lutheran Church. Alyssa also expressed that mental health care could be a very sensitive issue in many cultures that are represented at World Relief Seattle:

> Mental health is key to refugees' long-term success in the United States. There is no doubt that they will face challenges in their journey building their life in the U.S, especially in the beginning, so having access to mental health services will help refugees overcome barriers along the way and strengthen their outlook for future possibilities. Mental health has stigmas across many cultures, so referring clients to ICCS allows them to meet with someone who speaks their language and understands their cultural background in order to create an effective service plan (A. Van Hofwegen, personal communication, December 15th, 2014).

Alyssa shared that [in her role], she wants to create an "effective service plan for refugee health "(Van Hofwegen, 2014). This stood out to me because many times, agencies, non-profits or government systems leave this part out. *Effective* mental health care referral or aid comes after understanding the cultural background, after trust is built between the refugee and a caseworker who shares the same language or history.

A contact at World Relief, Seattle, who has done extensive research on immigrant and refugee populations and healthcare in the United States, confirmed that artistic healing *may be the most affective way ay to reach the vast mental healthcare* needs of the local refugee population (A. See, personal communication, December 29th, 2014). After asking Amanda her thoughts on World Relief, refugees and mental health care, she stated:

> I actually don't think many refugees would accept mental healthcare the way we offer it. Our concept of psychiatry is really Western, and it would have to be tailored to specific cultural, religious, and gender differences. For example, many Muslim men will not allow their wife to speak to any doctor alone, but must answer for her. This is frustrating enough in a "regular" doctor visit, but impossible in mental therapy. It is a strange concept for many non-westerners to trust a stranger with deep emotional thoughts and experiences, and I think most would not trust our system. In my opinion (which may be wrong) only the very liberal, westernized refugees would consider it. Plus, how many psychologists do you know who speak Somali? [A. See, personal communication, December 2014].

Amanda brought to my attention some very good points. Typical "talk therapy" and group therapy or one-on-one therapy, is going to be a strange reality to many refugees in the

Seattle area. Very rarely is it customary for other cultures to seek help in this way. Artistic healing can offer something less intimidating, and perhaps less intrusive. Participation expressed in a classroom setting is very different than doing it in a sterile psychiatrist office. Likewise, sitting on the floor in a circle or being outside might make some groups most comfortable. Participants, when presented with watercolors and paper receive a different message, than that of a notepad, office desk and couch. The sights, sounds, and experience may be more appealing to the refugee cultures in Seattle.

Amanda also discussed that even in Seattle the education and life experience of refugees are so vast. Some individuals who come to World Relief have been engineers or doctors in their home countries, working in a big city and making healthy incomes. Other refugees have lived in a crowded refugee camp since high school and have no higher education. However, unlike other aid workers concerns about artistic practices, my research supports the idea that artistic expression can equate to healing and "therapy". This type of expression can be used as a tool to eliminate walls and hurdles found in a therapy equation, while allowing room for vulnerability and participation without intimidation.

IV The Church, Refugees, and Mental Healthcare

Because health care is so limited and somewhat basic in form for refugees, the model that World Relief provides, through pointing refugees to the ICCS, is not only necessary but aligns itself with Christian principles that are often forgotten by the Church. In 1 Corinthians 14:33, Paul writes: "God is not a God of chaos, but of peace". When Christ came to earth as outlined in the Gospels, he started to rule over a new kingdom; a kingdom in which his Lordship would reign over all, including the government. Currently, many

government systems are in place to help the marginalized living in the United States. For example, the U.S. has the Welfare System, Child Protections Services and many other systems to help the poor and poor in spirit. *However* government systems will always fall short. Too often the Church has stood by and let the government create systems for the marginalized, when things should look radically different because of how Christ has restructured government and created a space for the Church to open its doors to service, aid and healthcare.

Obviously there are potential problems with religiously affiliated mental health programs. As previously stated, it is critical that the Church avoid spiritualization of the mental health care experience. However, the Church could and should provide a link and connection between struggling refugees and professional help. In one article the authors explain how, in African American churches and other faith based communities, only 18% of outreach programs to the public were concerned with mental healthcare issues, family counseling, youth at risk programs, abusive situations and marriage counseling (Taylor, 2000, p 78).

Artistic Healing, which can include drawing, writing, shared music, and other forms of art, can be democratized in a church setting. Trained developers and counselors can partner with churches to provide resources and tools needed for Artistic healing. Many churches collect funds to help the poor and vulnerable. These funds could be used to offer the tools, resources and staff to create an artistic healing group hosted in a church building. The church, the body of Christ, is able to take an active role in artistic healing. Anyone can learn to be a good listener and church members can provide tools and building space for

artistic healing group. All these practices, without words, proclaim the Love of Christ. The church should be a champion for artistic healing practices.

VI. A The Importance of Lamenting

In her dissertation, Dr. Lina Rong (2012), wrote about the importance of communal suffering and lamenting. In her text she indicated, "The book of Lamentations has become a liturgical prototype for a suffering community to deal with loss and pain" (p. 234). Rong (2012) continued to explain that the underlining point of importance is the community sharing of emotion, and the value this particular society places on a period of grieving. Empirical psychological research makes clear that people across age groups and cultures are all inclined to share their emotions, both positive and negative, with family and friends. We too often take moments out to reflect on loss or grieve what could have been. It is imperative that in an artistic healing session, the module and procedures allow time for grief. Sometimes Evangelistic Christianity can perhaps push an "ignore the grief" agenda, or a mentality of "what's to be sad about, when you know Jesus?"

Artistic healing sessions can create a safe space for lamenting and processing grief. Sometimes we do not have the words or vocal capacity to share how we are feeling. However, in a group setting sometimes we are given the confidence and attention the trauma and our souls deserve. I have observed in cultural contexts worldwide, humans are generally ashamed to be vulnerable. Sometimes the feelings of guilt and shame inhibit vulnerability and healing. Similarly, in my experience living in an Asian culture for 3 years I would say that lamenting or grief is completely non-existent. Likewise the Western Christian culture is ashamed to be vulnerable. We too quickly forget that from David, the Psalms, Paul, and Lamentations we are given pieces of a story that is broken. Even Christ on

the cross is broken and abandoned, and accuses God the Father of abandoning him. Christ cries out: "Eli, Eli, lama sabachthani, which means: my God, my God why has thou forsaken me?" (Matthew 27:46). The authors of the Bible, and Christ himself struggled and many times found themselves in the dark night of the soul. Many times they asked God why he has abandoned them. The author of Psalm 10 wrote: "Why Lord do you stand far off? Why do you abandon me in times of trouble?" (Psalms 10). Many times Christ's own followers, his disciples, felt alone, scared, hurt and traumatized. Throughout the Bible, God did not punish individuals for these expressions of lament and He did not discourage them from this vulnerability. In fact, the grief makes the stories richer, and more relatable. Parker J. Palmer's (2000) wrote:

> But before we come to that center full of light, we must travel in the dark. Darkness is not part of the whole of the story-every pilgrimage has passages of loveliness and joy-but it is the part of the story most often left untold. When we finally escape the darkness and stumble into the light, it is temping to tell others that our hope never flagged, to deny those long nights we spend cowering in fear. (p. 18)

Palmer (2000) went on to say that the darkness he faced and the seasons of depression he found himself caused his ministry and his work with people to be richer, more relatable and more real. Grief and lament are Biblical principles. Notably, God does not talk in the book of Lamentations. His voice is absent. Perhaps, when necessary, and appropriate, we developers, counselors, aid workers, must keep quiet too. We must allow space for true lamenting and grief to take place. Our booming reactive voices will only intimidate, anger, or shut people down. We must give people the opportunity to share their truth. We will do

refugees a disservice if we only encourage art expressions that we deem happy or hope-filled. Parker (2000) affirmed that our stories, journeys and troubling and distressful times would help us create a narrative that is helpful to others. If we deny the fact of our trauma, distress or personal darkness we are doing those around us a disservice.

Earlier, my paper addressed a problem in current mental healthcare: the fact that many refugees, in addition to talking about past grief, also wanted to talk about what is currently happening in their new home or in their "bridge" home (Watters, 2001). What distresses are refugees currently encountering? What is stressful at their children's new school? At the doctor's office? In their "middle" country's refugee camp? What are factors that are increasing their anxiety and depression? All of these questions should be part of artistic healing. Not only must participants be encouraged to produce art that reflects the past, but also the present. Furthermore, another thing to consider is to incorporate tradition from the particular culture. For example, the ringing of a bell or the lighting of a candle, into the workshop ritual could prove to be a familiar practice and can further instill trust.

VI.B Refugees as Leaders-Empowerment Through Art

A common idea behind mental healthcare is that when you suffer from depression, PTSD, or anxiety, you are unable to lead, you are unable to serve and your capacity for greatness is no more. Artistic expression not only can build a new framework of capability in an individual, but it also can establish beautiful leadership qualities.

In a 1920's play entitled "The Angel that Troubled the Waters" by Thornton Wilder (1928) that was based on the passage of Jesus healing at the pools of Bethesda, Wilder

created a new narrative for one of his characters when he instantly asks again and again for the angels to heal him. The angel's response:

> Without your wounds where would your power be? It is your melancholy that makes your low voice tremble into the hearts of men and women. The very angels themselves cannot persuade the wretched and blundering children on earth as can one human being broken on the wheels of living. In Love's service, only wounded soldiers can serve.

All humans, including refugees, deserve to be safe, healed, and empowered. No one should be treated like a broken vessel. Instead, each story should be owned humans in general, including refugees, long to be safe, healed and empowered. Yet, we must not communicate, as individuals and as a society, that they are merely broken vessels. Their story should be owned, it should be repeated and it should be used as a tool for empathy and understanding. The mindset of the mindset of our society can only be changed if refugees are given a voice, and one way this can happen effectively is through Artistic healing.

IV.C Final Thoughts

Mental healthcare is a right for every human. Unfortunately the "Western" approach to therapy and counseling is not always the best in a multicultural context, especially when mental healthcare is twisted in religious theologies and ideologies, or made unaffordable. It is a particularly huge challenge for refugees to have access to good mental healthcare. Refugee populations and those trying to emigrate, worldwide, at one point, live life on a bridge. They do not know what is on the other side. Sometimes these bridges, holding containers or second countries, are rusty, dilapidated and old. Sometimes the bridges are made from foreign materials. Sometimes the bridge journey is long. Refugees may travel

the bridge alone, or it may be crowded. On the bridge a person's identity may be misplaced or forgotten.

However, there is hope to be found. Shared experiences, poetry, art and community can be the saving grace that will sustain a refugee on his or her journey. Sharing pain, hurt, successes, and hope in written form, and through artwork or drama, can create a permanent voice that transcends manmade borders. Artistic healing gives the refugee the chance to be known, even in the darkest of moments. And to be known is to be loved.

While the other side of the bridge, whether it takes 6 months or 10 years to cross, may not be glamorous or glorious, the presence of a piece of artwork, a shared story or poem will be able to become a path of healing that can assist with the soul care of an individual who may have experienced much darkness, loss and trauma in life. This experience can remind therapy participants of community that saw them through the bridge journey, tools that they have learned along the way, and a reminder of the trust they built with those around them. Furthermore their culture and their home may be preserved through certain oral or storytelling artistic mediums. A piece of what once was can now be a reality in their new home. A reflection of the past, using art, will be a reminder that there is trust to be found in their new cultures and new "home" countries.

Afterword

While I was being treated at the clinic in Houston, I readily laughed off the sweet art therapist that would come around to our unit asking us if we would like to make collages or drawings. Likewise I only ventured into the craft room once or twice when it was my unit's turn to inhabit this beautifully resourced room. I found the notion laughable. I was a working professional, a graduate student—I had no need for crate paper and glue sticks. Unfortunately during my time in the hospital I did a terrible job at taking advantage of the artistic healing measures that were provided me. Writing this thesis has caused me to realize how wrong I was about art and healing. Personally, in the months following my discharge, I found that things such as: music, writing, painting and attending art performances were all things that breathed life into my soul and kept it afloat. Granted, I had learned new skills during my nine-week stay in Houston, and currently I still attend therapy sessions, however artistic pathways continue to breathe new life and dreams into me. A few days ago I found myself like the Seattle weather outside: grey, rainy and gloomy. I turned to my oil pants and canvas and found a new sense of capability and renewed hope. After this experience of research, interviews, and my attempts at becoming an "expert", I realize that I must become a master of using artistic healing, daily, in order to be my healthiest self.

I will close with thanks and gratitude. To my reading group, Monica and Ambassador-thank you for your gracious feedback and patience with my writing. Cohort 6, you have been my closest friends and my saving grace on my darkest days. Thank you. To my expert reader, author E. Gail Kretchmer: Thank you for your editing skills, your challenging questions and feedback on my drafts. You are someone who I admire and look

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