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AN INVESTIGATION OF THE IMPACT OF SANDPLAY THERAPY
ON MENTAL HEALTH STATUS AND RESILIENCY ATTITUDES
IN MEXICAN FARMWORKER WOMEN

by

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A dissertation submitted in partial fulfillment of the requirements
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ABSTRACT

This study investigated the impact that sandplay therapy sessions had on Mexican farmworker women's mental health status and resilience attitudes. The participants of this study were 40 women who were born in various states in Mexico and presently reside in rural Central Florida. Twenty women participated in the control group and twenty women participated in the treatment group. The impact sandplay therapy has on participants' mental health status was measured by Outcome Questionnaire (OQ-45), which assesses progress in therapy; and Resiliency Attitudes Scale (R.A.S.), which determines resiliency attitudes. The study also includes twenty participants' transcriptions of their individual sessions to illustrate the experiences of Mexican farmworker women with sandplay therapy. Pre and post-tests revealed a significant impact on mental health status and resiliency attitudes on the treatment group. In addition, participants also reported their own conceptualization of resilience that points to the integration of social networks, community resilience, solidarity, and hope.

I dedicate this to the memory of my son, Ian Joshua, who gave me the strength and resilience to pursue my education. This work is dedicated to many voiceless women before us who had no opportunity to express themselves. Education is power.

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LIST OF ABBREVIATIONS

OQ-45.2: Outcome Assessment Questionnaire

R. A. S.: Resiliency Attitudes Scale

MFW: Mexican Farmworker Women

CHAPTER ONE: INTRODUCTION

As national attention begins to focus on racial disparities in health care (U.S. Department of Health and Human Services, 2000), the Surgeon General has raised concerns about access to mental health services for ethnic minority women (U.S. Public Health Service, 2000). One growing population in the United States at particular risk for not receiving specialty mental health care is Latina women (Lillie-Blaton, Martinez, Taylor, & Robinson, 1993). Latinos/Latinas have been found less likely than others to receive health care services because of such factors as disproportionate numbers without health insurance, lack of help-seeking patterns, and an unrecognized need for services (Flores & Vega, 1998; Guarnaccia, 1997; McMiller and Weisz, 1996; Organista, 2000).

According to the U.S. Bureau of the Census (2001a), Latino/Latina individuals are now the largest minority group in the United States, with a population of nearly 36 million. Furthermore, the U.S. Bureau of the Census (2001b) estimates that individuals of Mexican descent comprise the largest Latino/Latina group. Despite these estimates, there are few studies that assess mental health status or resiliency attitudes within this population and no studies addressing these issues specifically with Mexican farmworker women (MFW). Mexican farmworker families have been specifically found to underutilize mental health care (Bui and Takeuchi, 1992; McCabe, Yeh, & Hough, 1999; Vega, Kolody, Aguilar-Gaxiola, & Catalon, 1999), and, there has been little effort in developing and evaluating accessible, evidence-based interventions specifically for Mexican farmworker women. Delivering appropriate and accessible therapeutic modalities for this group can address key financial and structural barriers

that often prevent Mexican farmworkers from receiving needed services (Garrison, Roy, & Azar, 1999).

Statement of the Problem and History

This investigation focuses on the impact sandplay therapy has on mental health status and on resiliency attitudes among Mexican farmworker women. Current literature (Flores & Vega, 1998; Guarnaccia, 1997; McMiller & Weisz, 1996; Organista, 2000) reveals a number of economic, sociological, psychological, and educational factors that impact their mental health and well being of Mexican farmworker women. Specifically, Mexican farmworkers are among the poorest, most marginalized, and exploited Latinos in the United States. Seventy seven percent of U. S. farmworkers are Mexican born (U.S. Farmworker Fact Sheet, 2003). Although they are part of a century-and-a-half old tradition of supplying essential, labor-intensive work to multi-million and billion dollar industries and corporations, they struggle and toil at the bottom of the U.S. economic stratification system, where they are extremely vulnerable to numerous life-compromising problems and circumstances (Organista, 1998).

America has long benefited from inexpensive and plentifully available produce on market shelves, yet few Americans realize how the produce they consume reaches them. The reality is that American agriculture is highly dependent on the hand labor of migrant and seasonal farmworkers. Massive availability of migrant labor began in earnest during the Great Depression when many people lost their small, independently run family farms and had few other options for economic survival (U.S. Farmworker Fact Sheet, 2003). The history of migrant labor has long been dominated by images of forlorn sharecroppers and hopeful Mexican men allowed to enter

the U. S. through the Bracero Act during the labor shortages of World War II (U.S. Farmworker Fact Sheet, 2003).

According to the National Center for Farmworker Health, farmworkers suffer from the highest rate of toxic chemical injuries of any workers in the U. S. (U.S. Farmworker Fact Sheet, 2003). Farmworkers and their families suffer higher incidences than other wage-earners of heat stress, dermatitis, influenza, pneumonia, pesticide related illnesses, and tuberculosis (U.S. Department of Labor, 1990). The infant mortality rates are considerably higher among migrant farmworkers than the rest of the U. S. population (U.S. Farmworker Fact Sheet, 2003). Few, if any, migrant farmworkers have health insurance, and very few are covered through Medicaid (National Agricultural Workers Survey, USDOL, 1997). Despite their poverty, few farmworkers use social services. In fact, about 100,000 foreign-born farmworker households have been excluded from each of the major programs such as food stamps, Medicaid, and The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) due to legislation passed by the 104th Congress (National Agricultural Workers Survey, USDOL, 1997). Studies focusing on farmworker women, show that women earn less doing farm work than their male counterparts: the median annual income for female farmworkers is \$2,500-\$5,000, while the median annual income for male farmworkers is \$5,000-\$7,500 (National Agricultural Workers Survey, USDOL, April 1997). All these facts point to an exposure to serious risk-factors and to the importance of developing mental health programs to serve this underprivileged population. However, few programs have been rigorously evaluated and even fewer are designed specifically for Mexican farmworker women.

Purpose of the Study

Based on historically documented obstacles and risk-factors that farmworkers endure, there is an evident need for providing health services in general, but more specifically mental health services in farmworking communities. As counselors, there is an ethical responsibility to engage actively in considering ways to support and provide services to underrepresented and voiceless ethnic minorities. In order to account for social context and to give voice to farmworker women's experiences through therapeutic interventions it is imperative to create an environment where these women are not intimidated to share and voice their stories. The use of creative therapeutic interventions such as sandplay therapy is one methodology by which this population expresses itself and feel less apprehensive about participating in counseling.

The purpose of this research is primarily to uncover the impact of sandplay therapy on Mexican farmworker women's general mental health status and resiliency attitudes. More specifically, the intent of the study is to focus on sandplay therapy and the impact it has on clients' mental health status measured by progress in therapy provided by the OQ-45.2 (Lambert, Hansen, Umpruss, Lunen, Okiishi, Burligame, Huefner, & Resisinger, 1996); and on this population's resiliency attitudes measured by the Resiliency Attitudes Scale, R.A.S. (Biscoe & Harris, 1999). In addition, focus groups and individual sessions are qualitatively studied and analyzed to render a broader and richer investigation.

Social, Political, and Economic Context

When considering migrant farmworkers one usually imagines them to be men, the thought of women as a significant part of this population is probably an afterthought at best, and

even then most people would greatly underestimate their numbers. From the estimated 2.5 million migrant and seasonal farmworkers in the U.S. today, more than 1/4 are women (U.S. Dept. of Labor, 1994). Therefore, it is important to recognize the role of women in farmwork. 'Migrant farmworker' is a broad term describing people who migrate to perform various agricultural jobs and who belong to various ethnic, gender, and age groups (U. S. Department of Labor, 1990).

Often women are further confined by being assigned lower-paying tasks resulting in incomes two thirds less than those of their male counterparts (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000). There is also a discrepancy in the amount of benefits extended to farmworker women as compared to men. Twenty four percent of farmworker men receive paid sick leave and 49% have health insurance, while only 11% and 35% of farmworker women have the same benefits, respectively (The Committee on Women in Agriculture, 1993). In spite of these discrepancies in pay and benefits, economic realities force most farmworker women to accept any job they can obtain. Migrant farmworker women are 2.5 times more likely to be unemployed than men (U.S. Dept. of Labor, 1994). Even those women who find employment do not receive continuous pay because there is no full-time work. The average annual period of employment of a farmworker woman is 4.9 months (The Committee on Women in Agriculture, 1993).

As governmental agencies begin to focus on the mental health care of ethnic minorities, it is imperative that sound research is conducted on the specific mental health needs of farmworker populations. This investigation explores a specific modality by which mental health services can be provided to farmworker women. As the literature (The Committee on Women in Agriculture,

1993; Lillie-Blaton, et al., 1993; Alderete, et al., 2000) suggests, farmworker women represent a considerable portion of the total number of farmworkers in the United States, and as women, they have unique needs and responsibilities such as childcare, healthcare, prenatal care, etc. These issues directly affect MFW's mental health and therefore point at the need for providing services to this voiceless and marginalized population.

Rationale of the Investigation

Sandplay literature (Livingston, 2002; Ammann, 1991; Amatruda & Simpson, 1997) shows that studies have been conducted predominantly in children and adolescent populations who have endured tragic events. Additionally, resiliency studies have focused predominantly on families (Grotberg, 1995; Biscoe & Harris, 1999; Wolin & Wolin, 1993). This study focuses on MFW's experiences with sandplay therapy and the impact this therapeutic model has in MFW's mental health status and their resiliency attitudes. The choice of figures, their placement and movement through the trays and the statements that accompany these actions as well as standard verbal therapy will be analyzed in order to discover MFW's resiliency attitudes. Sandplay is the catalyst to explore this population experiences and self-generated solutions found through the therapeutic process. It is important to investigate how different therapeutic modalities impact MFW in order to promote an increased number of mental health services for ethnic minority communities around the nation.

Theory Base for the Research

A debate among feminist psychologists and counselors exists about how best employ nonsexist research practices, which should be a minimum requirement of all work toward new feminist approaches to research. Sandra Harding (1987) concludes that it is not by looking at research methods that one will be able to identify the distinctive features the best of feminist research. Rather, Harding (1987) suggests feminists differ from other researchers in the theories they use, the ways they apply theories to specific problems, and in their general beliefs about how knowledge is constructed (their epistemologies).

There are several implications for research when it is structured on the basis of feminist psychology and counseling constructs. First, it leads feminist researchers to emphasize the effects of social and cultural contexts on human experiences. This often includes a heightened concern with the impact of social class, race, ethnicity, age, and sexual orientation. Thus, there is an insistence that human behavior cannot be understood apart from its social environment. Second, this belief leads feminists to consider the diversity that exists among women and men. As some researchers (Fonow & Cook, 1991; Harding, 1987) have concluded, the notion that there is no universal man implies that there is also no universal woman. Women's lives and experiences are varied. Third, this view ultimately leads feminist researchers to be skeptical of the possibility of establishing universal facts or laws about human behavior. The framework of this investigation is firmly based on the above feminist constructs.

Research Questions and Objectives Investigated

This investigation aims to answer the following questions:

(1) Is there a difference in MFW's mental health status measured by the Outcome Questionnaire (OQ-45.2) after they have participated in six sandplay therapeutic sessions?

(2) Is there a difference in MFW's resiliency attitudes measured by the Resiliency Attitude Scale, R.A.S. (Biscoe & Harris, 1999)?

(3) Is there a difference in MFW's mental health status and resiliency attitudes between treatment group and control group?

(4) What themes and patterns (gathered through video and audio tapes from one-on-one therapeutic & focus group sessions) does sandplay therapy uncover when working with MFW?

(5) What resilient images (gathered through video tape and photographs) are uncovered in sandplay therapy with MFW?

Null Hypotheses:

(1) There is no significant difference in MFW's mental health status after participating in Sandplay therapeutic sessions.

(2) There is no significant difference in MFW's and resiliency attitudes after participating in Sandplay therapeutic sessions.

(3) There is no significant difference in MFW's mental health status or resiliency attitudes between the treatment group and the control group.

Alternate Hypothesis:

(1) There is a significant difference in MFW's mental health status after participating in Sandplay therapeutic sessions.

(2) There is a significant difference in MFW's and resiliency attitudes after participating in Sandplay therapeutic sessions.

(3) There is a significant difference in MFW's mental health status or resiliency attitudes between the treatment group and the control group.

Conceptual and Substantive Assumptions of the Study

This investigation makes the following assumptions:

(1) Sandplay therapy may have a potential impact on mental health status and resiliency attitudes in MFW.

(2) Participants are accurate in reporting their assessments.

(3) MFW experience resiliency.

Definitions and Operational Terms

Mexican: Person born in Mexico and currently is residing in the United States.

Farmworker: An individual or direct family member of an individual whose principle employment is in agriculture.

Sandplay Therapy: Sandplay utilizes sandtray, water, and a variety of small objects and materials to imaginatively create scenes in the space of the sandtray. The sandtray is a space where the client has the opportunity to create her own world and transform her existing world with fresh insight. In sandplay the client represents her inner and outer world by way of images. By making concrete what the inner voice is expressing, the client brings into external reality her

own relationship with herself and allows unconscious material to be revealed (Labovitz-Boik & Goodwin, 2000).

Mental Health Status: Defined by the OQ-45.2, which measures therapy progression by three subscales: Symptom Distress, Interpersonal Relations, and Social Role (Lambert, et al., 1996).

Resilience: Wolin and Wolin (1993) define resilience as the capacity to bounce back, to withstand hardship, and to repair oneself.

Resilient factors: Seven characteristics identified as the constellation of strengths among individuals and measured by R.A.S.: insight, independence, relationships, initiative, creativity and humor, and morality (Biscoe & Harris, 1999).

Chapter Two presents the relevant literature regarding the study. This chapter begins with a brief history of Mexican farmworkers living in the United States. Second, the focus is on sandplay therapy literature and its applications with adults. Third, there is a discussion of the literature regarding mental health and resilience with MFW followed by a summary.

CHAPTER TWO: LITERATURE REVIEW

Mexican Farmworker Women in the United States

The U.S. Public Health Service (2000) estimates a total of 3.5 million migrant and seasonal farmworkers in the United States. This includes families with children, single men and women, and some older men and women. Approximately one half of migrant farmworkers have completed less than a ninth grade education, and many speak little or no English. Migrant farmworkers usually have their permanent residence or homebase in California, Texas, Florida, Mexico and Puerto Rico. As each new crop is ready for harvest, they travel across the nation (Hansen & Donohoe, 2003).

Most farmworkers earn annual incomes below the poverty level and half earn below \$7,500 per year (Organista, 2000). Despite earning such low incomes, these are proud people who choose to do backbreaking labor rather than depend upon charity or welfare. Rarely do they have access to occupational rehabilitation or disability benefits despite eligibility for Medicaid, food stamps, and Nutritional Supplements Program for Women, Infants, and Children (WIC) if they live in one area long enough to secure these benefits (Organista, 2000). While undocumented immigrants are not eligible to receive most forms of public assistance, they do have protected rights with regard to wages, health, safety standards, and workers' compensation (Organista, 2000).

In the agricultural industry, both men and women face the occupational hazards of pesticide exposure, long hours of fast-paced repetitive tasks without breaks, and a lack of toilets and drinking water in the fields (Farmworker Justice Fund, 1994). When not in the fields,

migrant farmworkers are most often housed in substandard labor camps (Organista, Ball, Organista, García de Alba, Castillo Moran, & Ureta Carillo, 1997). They are often isolated and living in remote rural areas. Women often find themselves dependent on their husbands and crew leaders for transportation and many experience sexual harassment and violence (Hansen & Donohoe, 2003). In 1995, one third of farmworker women reported that they had experienced domestic violence over the course of the previous year (Migrant Clinician Network, 1995).

Once there is awareness of the large number of women doing farmwork, there is a need to explore the differences that exist between the lives of migrant farmworker men and women. Migrant farmwork is a difficult job, regardless of whether one is male or female. Farmworker advocates have witnessed and documented deplorable conditions and low pay for some time. However, as is the case in most jobs, women are often subject to uniquely difficult experiences. Though women do nearly every kind of farm labor on every kind of farm, they routinely earn less than men for doing the same work (Organista, et al., 1997).

Even though there are some facts and figures, few studies (Hovey & Magaña, 2002; Lillie-Blaton, et al., 1993) have been conducted on the lives of farmworker women. Grouping all "migrant farmworkers" together as if they were one homogeneous group of people does not increase awareness of the special circumstances that farmworker women often face. For instance, such statistics cannot begin to depict or adequately predict the needs of real farmworker women like María, who has to carry her four children to the field with her as she labors over the fern plants in the Central Florida area; or Ana, who is a farmworker and an organizer of farmworker women. Before a just and empowering political and economic system can be established, the voices of farmworker women must be heard. One example of real stories of farmworker women

comes from the writings of Maria Elena Lucas, who eloquently documents the lives of farmworker women in her book *Forged Under the Sun* (1993).

There are many issues one must consider when approaching counseling with Mexican farmworker women. It is important to take into consideration social context when providing counseling to this population. In order to account for social context and to give voice to farmworker women's experiences through therapeutic interventions, counselors must create an environment where these women are not intimidated to share and voice their stories. The use of creative therapeutic interventions is one methodology by which members of this population might express themselves and feel less apprehensive about participating in counseling.

Sandplay

Children have always enjoyed playing in the sand, bringing their inner and outer worlds together through imagination. Different cultures have historically used sand in imaginal rituals of visioning. The Dogon medicine men of Mali draw patterns in the sand and later read the paw prints left in the night by the desert fox to divine the future (Amatruda & Simpson, 1997). Tibetan Buddhist monks spend weeks creating the Kalachakra sand mandala, which is used for contemplation and initiation into Tantric practices (Amatruda & Simpson, 1997). Donald Sandner (1991), in *Navaho Symbols of Healing*, writes about the Navaho sand painting ceremonies in which images of world order are created to invoke the healing powers that bring the psyche of the people back into harmony with the universe. Upon the completion of each of these rituals the sand is brushed away and the images dispersed (Sandner, 1991). Therefore, it is

not surprising that psychotherapists and counselors have stumbled upon playing in the sand as a therapeutic method.

During the thirties, sand tray therapy developed in Europe as the Lowenfeld World Technique. Most sandplay therapists and writers (Allen, 1988; Carey, 1990) identify British pediatrician Margaret Lowenfeld as the first person to describe sandplay as a therapeutic technique, formulate and articulate the associated theoretical principles, and train many practitioners worldwide. Lowenfeld (1979) credits a child with bringing small objects in her room over to the tray with sand and naming them sand trays “worlds.” A world can be seen as a picture of the psyche according to Lowenfeld (1979), who notes that “The World Technique” is characteristically a right brain mode. She states that the production of worlds seems to be halfway between dreams, which are an unconscious creation, and art, which draws from the conscious, in the creation of structure and form (Lowenfeld, 1979). Violet Oaklander (1978) was among the first child psychotherapist in the United States to write about the value of sandplay in child psychotherapy.

In 1956, Dora Kalff studied with Margaret Lowenfeld in London for one year. Initially influenced by Emma and Carl Jung and by her immersion in Tibetan Buddhism, Kalff developed her own version of sandplay by combining Eastern thought, Neumann’s (1976) stage theory of ego development in early childhood, and Jung’s theory of individuation (Stewart, 1995). Her ultimate impact on sandplay, however, came from traveling the world for 35 years lecturing on sandplay to public audiences and training professionals (Ryce-Menuhin, 1992), single-handedly creating a worldwide community of sandplay therapists (Stewart, 1995).

Two additional pioneers of sandplay therapy deserve brief mention. A short time after

Lowenfeld developed the “World Technique”, Erik Erikson developed the Dramatic Production Test (DPT) at Harvard in the 1930s. The DPT used miniatures in a defined space for therapeutic and diagnostic purposes and stemmed from his and Freud’s result. Children’s play was viewed as a series of visual and sensory images that expressed the child’s life and “only later could these images be put into words” (Mitchell & Friedman, 1994, p.25). Erikson used the DPT to study human development in children and character formation in college students by examining how they placed miniatures in a defined space. He told participants he was interested in ideas for moving picture plays and asked them to use the toys on the table to construct a dramatic scene. Erikson also focused on both, the process of creation as well as the outcome or content of the scene created (Mitchell & Friedman, 1994). A few years later, Charlotte Buhler saw the “World Technique,” incorporated it into a diagnostic kit called the “World Test,” and distributed it to clinicians in the United States through the Psychological Corporation (Bradway, 1979). As with Erikson’s DPT, the “World Test” miniatures were not placed in sand, but rather on either a designated table or on the floor (Mitchell & Friedman, 1994).

Linda Hunter (1998) has done extensive research on sandplay therapy and resiliency with children. Her work focuses on children who have been labeled by society as “emotionally disturbed” and “bad” (Hunter, 1998). She notes that the children in her studies used the “language of sand, water, and many, many small figures to explore inner strengths and find the resiliency that exists in their imagination” (Hunter, 1998). This investigation is makes a new contribution to the study of sandplay and resiliency, in that the target population is Mexican farmworker women.

Sandplay Procedures

In sandplay, the client creates a three-dimensional scene in a tray of sand using a selection of miniatures (Coalson, 1995). Following Kalff's model, therapists usually provide two trays for children, each approximately 20x20x3 inches in size, as this dimension allows the client and therapist both to view the entire tray in one glance without moving their eyes and heads (Mitchell & Friedman, 1994). This context also serves as a "neutral starting point" and provides the client with a "free and protected space" in which to work (Greenhalgh, 1994, p. 304). It is "free" in the sense that clients can create anything they want to express; it is "protected" in that the clients' sandworlds are naturally bound by the physical parameters of the tray (Greenhalgh, 1994; Ryce-Menuhin, 1992).

Kalff's (1980) method of sandplay has two distinct parts: the first part is for the client to make a picture; the second part is for the client to tell a story or narrative about the picture. Following a brief introduction she invites the client to look at the materials "until you find something that speaks to you and put it in the tray and then add to it as you wish" (Mitchell & Friedman, 1994, p.83). Oaklander (1978) instructs her adolescent clients to "Close your eyes and visualize for a moment, your world. Now build a scene to represent what you saw in your mind's eye" (p. 169). Other therapists simply encourage the client to create a scene, picture, or whatever they wish in the sand (Wienrib, 1983).

The therapist serves as a companion in the sandplay process, rather than the controller or director (Baum, 1994) and shares the experience, but does not direct it (Stewart, 1995). During the creation of a sandworld, the therapist usually sits close enough to the sandtray to observe what transpires, but not so close as to seem intrusive to the client (Stewart, 1995), and

demonstrating unconditional positive regard for the client and her creation (Allen, 1988). It is often important to maintain an atmosphere of “concentrated silence” (Ryce-Menuhin, 1992, p.32); in this observation time, therapists should pay careful attention to what the client uses and does not use, as well as how he or she uses these objects (Earle, Earle, & Osborn, 1995), including their placement, groupings, and boundaries.

An important role for therapists is that of recording and dismantling the sandworld. Again, the process of recording varies among therapists. Some therapists photograph the sandtray or complete a protocol describing the content and process (Earle et al., 1995), or both. Others may sketch the sandworld and/or take notes about the process (Ammann, 1991). Some therapists believe it is beneficial to give clients a photographic copy of a particularly meaningful creation for them to keep and possibly to journal about the sandtray process (Sweig & Sachs, 1993). Clients may additionally benefit from this because they see their efforts have not being wasted or lost, and instead their creations have been received and valued (Reed, 1975).

Sandplay may open the person to re-experience pre-verbal and non-verbal states. Children recognize language before they can speak. Adults may have forgotten or never learned words for some inner experiences, yet they may recognize a figure intuitively without being able to recall why or what it is. That is why sandplay therapists sometimes say, “Let the figure pick you!” (Perkins McNally, 2001). Other elements of sandplay also enhance the experience. The size of the tray itself is meant to hold a person’s gaze, which may encourage a concentration and intensification of the psyche’s energies. The three-dimensional figures also offer fullness of representation that does not require skill. Even a three year old can build complex, multi-dimensional scenes. These figures can facilitate a person’s ability to differentiate experiences

and link separate meanings by bringing them further into consciousness. Like the alchemical vessel, the tray within the relationship between the person and the therapist contains and intensifies the heat and pressure so that change can occur.

Sandplay's efficacy comes from creating the sand picture itself as a form of active imagination, and not in focusing on cognitive processing or on the completed production. Sandplay pictures are generally not interpreted while a process is ongoing so that the client can stay close to the living experience in their body and imagination. The therapist is a witness who primarily reiterates empathically to the person playing in the sand. Sandplay is usually done adjunctively to verbal therapy, which carries the interpretive aspects of the psychotherapeutic work. Additionally, review and more analytic discussion of the trays themselves can occur any time after the process is completed.

During sandplay therapy sessions, clients are encouraged to express themselves and are allowed to play with their scene by placing figures in the sandtray. If clients earnestly participate by moving and changing figures in the sand, transformation occurs because the sandtray process teaches clients self-acceptance. For example, one theme that is frequently created in the tray is personal trauma. Those traumas may be child abuse, divorce, disasters, or death of a loved one. Memories, feelings, understandings, and experiences are continually created in the sand, which can then be confronted and processed on an intellectual, emotional, or spiritual level (Livingston, 2002).

Mental Health

A review of the literature in this area reveals very few studies (Hovey & Magaña, 2002;

Guarnaccia, 1997) on mental health and farmworker women. Joseph D. Hovey, Director of the Program for the Study of Immigration and Mental Health at the University of Toledo, has written extensively about the mental health of farmworkers in the United States. According to Hovey & Magaña (2002b), a list of stressors commonly experienced by Mexican migrant farmworkers in Michigan and Ohio include, but are not limited to, the following: (1) language barriers; (2) worries about the socialization of their children (e.g., children encountering different moral values in mainstream society and deterioration of family values); (3) lack of daycare and supervision for children; (4) poverty and lack of necessary resources such as food and clothing; (5) social isolation, with geographical location making it difficult to meet people and to find a place to shop; (6) exploitation by employers (e.g., being paid lower wages than what was agreed; not being paid on time; excessive prices for food and housing supplies); (7) fear of violence in the community (e.g., domestic violence; violence due to drugs and alcohol); (8) health-related concerns such as a poor health, limited access to medical care, and the migrant community's lack of knowledge regarding sexually transmitted diseases (e. g., HIV and AIDS) (Hovey & Magaña, 2002b).

The above research is relevant because it provides a comprehensive summary that ties together the disparate stressors that other researchers have found among Mexican migrant farmworkers in south Georgia (Perilla, Wilson, Wold, & Spencer, 1998), North Carolina (Clifford, 1999), Oregon (Wiggins & Castañares, 1995), California (Mines, Mullenax, & Saca, 2001) and Puerto Rican and African American migrant farmworkers in upstate New York (Harper, Babigian, Paris, & Mills, 1979). More importantly, it details the circumstances that make farmworkers susceptible to such mental health problems such as depression, anxiety,

substance abuse, domestic abuse, and suicide.

In another investigation, Hovey & Magaña (2002a) acknowledge that scant research has examined the mental health of migrant farmworkers in the United States. The purpose of their study was threefold: (1) to assess the prevalence levels of anxiety symptoms in a sample of Mexican migrant farmworkers in the Midwest United States; (2) to examine the relationship between acculturative stress and anxiety; and (3) to determine the variables that significantly predict anxiety. High levels were found for overall anxiety as well as in the cognitive, affective, and physiological expressions of anxiety. Elevated acculturative stress, low self-esteem, ineffective social support, lack of control over choice of occupation, low religiosity, and low education were significantly related to high anxiety levels. The overall findings suggest that Mexican migrant farmworkers who experience high acculturative stress may be at risk for developing anxiety-related disorders. These findings highlight the necessity of establishing prevention and treatment services for migrant farmworkers that increase levels of emotional support, self esteem, and coping skills (Hovey & Magaña, 2002a).

Hansen and Donohoe (2003), in an article entitled “Health Issues of Migrant and Seasonal Farmworkers,” describe the socioeconomic conditions under which migrant seasonal farmworkers live in the United States. They show that, health consequences result from occupational hazards, poverty, substandard living conditions, migrancy, language and cultural barriers, and impaired access to health care. Specific problems include infectious diseases, chemical and pesticide related illnesses, dermatitis, heat stress, respiratory conditions, dental diseases, cancer, poor child health, inadequate preventative care, and social and mental health problems.

Vega, et al. (1999), of the Department of Health Policy Administration in the School of Public Health at University of California, Berkeley, examined the prevalence of and risk factors for twelve psychiatric disorders by sex and ethnicity (Indian versus non-Indian) among Mexican migrant farmworkers working in Fresno County, California. Subjects aged 18 through 59 years were selected under a cluster sampling design (N= 1001) and a modified version of the Composite International Diagnostic Interview was used for case ascertainment. The effects of socio-demographic and acculturation factors on lifetime psychiatric disorders were tested. Lifetime rates of any psychiatric disorder were as follows: men, 26.7% (SE = 1.9); women, 16.8% (SE = 1.7); Indians, 26.0% (SE = 4.5); non-Indians, 20.1% (SE = 1.3). Total lifetime rates consisted of the following: affective disorders, 5.7%; anxiety disorders, 12.5%; any substance abuse or dependence, 8.7%; antisocial personality, 0.2%. Lifetime prevalence of any psychiatric disorder was lower for migrants than for Mexican-Americans and for the U.S. population as a whole. High acculturation and primary U.S. residence increased the likelihood of lifetime psychiatric disorders. The results of this investigation underscore the risk posed by cultural adjustment problems, the potential for progressive deterioration of this population's mental health, and the need for culturally appropriate mental health services.

A study by Vega, Scutchfield, Karno, and Meinhart (1985) published in the *American Journal of Preventative Medicine*, reviewed the use of three measurement procedures to produce a comprehensive profile of the mental health needs of Mexican-American farmworkers and determined the kinds of mental health services required to meet those needs. These measurement procedures comprised a field survey, a key informant survey, and a nominal group process. The results of the field survey indicate that rural Mexican-Americans are not being served by mental

health providers, despite having higher symptom levels than would be expected in the general population and a substantial use of rural primary health clinics and private physicians. The key informant survey included mental health providers, medical health providers, and community agency personnel. According to these informants, the mental health sector is unable to provide services for the farmworkers and the ability of other providers to reach them depends on a number of factors, including the nature of the services offered and the socioeconomic characteristics of the farmworkers themselves. Key informants identified the environmental conditions implicated in the farmworkers' psychosocial problems and recommended types of services, sites, and necessary personnel. Additionally, key informants concurred that general health settings and multiservice agencies were the most appropriate for reaching Mexican Americans, and that mental health services must include bilingual and bicultural staff members; they disagreed, however, about the relative value of certain kinds of mental health services.

Literature review (Hovey & Magaña, 2002a & b; Flores & Vega, 1998; Hansen & Donohoe, 2003) for the field of mental health and farmworkers supports the need for further investigation of mental health projects that can adequately address the needs or offer support to this population. Moreover, studies that address mental health include farmworkers as a whole and there are no specific studies that address specific mental health needs of Mexican farmworker women. This investigation aims at examining how sandplay therapy impacts the mental health and resiliency attitudes in MFW.

Paradigm Shift: From Pathology to Resilience

The concept of resilience has been investigated and developed through various authors

(Werner & Smith, 1982; Garmezy, 1985; Biscoe & Harris, 1999; Wolin & Wolin, 1993). The focus of psychological research has primarily been to determine pathological or risk factors with which people cope in life. Many studies, for example, focus heavily on ways to identify the damage done to children and to provide services to help them develop with the exposure to risks in their lives. After discovering that close to one-third of the children living with such risks and pathology were also well adjusted, happy and successful, researchers sought to account for the success of these children (Werner & Smith, 1982; Garmezy, 1985).

An important reply came from William Frankenburg, M.D. (1987), in his opening statement to the Fifth International Conference on Early Identification of Children at Risk: Resilience Factors in Prediction:

One thing that has become clear from the four previous conferences is how often researchers and care providers alike have been caught up in a pathological model of looking at children. We have focused on looking for problems, a negative approach that may sometimes have the undesirable effect of causing parents to think negatively about their children. That is why the Fifth International Conference will focus on those resilience and self-righting factors – those strengths – that seem to protect some children who are at high risk for developmental disabilities (Frankenburg, 1987).

This statement captures the essence of the problem with focusing on pathology. The Bernard van Leer Foundation, which supported a conference held in the Kingdom of Lesotho in 1991, made an additional point critical to the study of resilience: the need to recognize some traits and characteristics children had that were different from or not as frequently found in children who were not resilient. The focus of this conference was Building on People's

Strengths: Early Childhood in Africa (The Bernard van Leer Foundation, 1994). Other national and international meetings on resilience followed these conferences with greater clarity regarding involvement with children who overcame odds.

Furthering the development of the concept of resilience encompassed recognizing some traits and characteristics of resilient people. Various researchers and practitioners have identified some resilient traits, although there is no consensus in the literature (Werner & Smith, 1982; Garmezy, 1985; Biscoe & Harris, 1999; Wolin & Wolin, 1993). The International Resilience Project, who organized resilient traits into the following categories, offers one of the most popular conceptions of resilient traits:

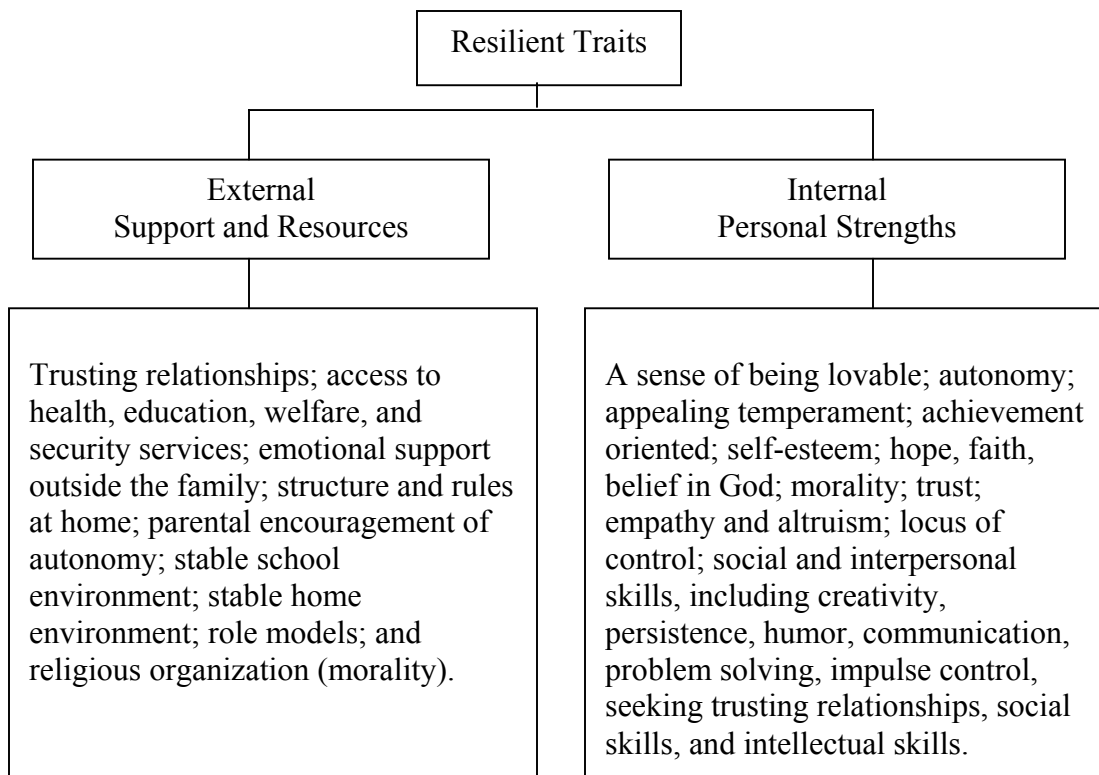


Figure 1: The International Resilience Project: Categories of Resilient Traits

Recognizing features of resilience does not mean there is agreement on how to identify and define it. Defining resilience is a continuing problem (Kaufman, Cook, Arny, Jones & Pittinsky, 1994) due to a lack of consensus about the domain covered by the concept of resilience, e.g. its characteristics and dynamics (Gordon & Song, 1994). There have been several instruments attempting to measure resilience, but no single instrument measures all the traits encompassing resilience. The Spanish language, for example, has no word for resilience in psychological literature but instead uses the term “la defensa ante la adversidad” (Grotberg, 1993). The concept of resilience has evolved with increased acceptance of its appropriateness in the social sciences (Manciaux, 1995).

The International Resilience Project provides a popular definition of resilience.

Resilience is defined as “the universal capacity, which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity” (Grotberg, 1995, p. 2).

Resilience may transform or strengthen the lives of those who possess this quality. The resilient behavior may be in response to adversity in the form of maintenance of normal development despite adversity, or a promoter of growth beyond the present level of functioning. Furthermore, resilience may be promoted not necessarily because of adversity, but indeed, may be developed in anticipation of inevitable adversities.

According to Wolin and Wolin (1993), resilience is an interaction of both internal and external factors that impact an individual. Of course, resilience develops as both the internal and external interact. Caring relationships, for instance, can trigger a positive cycle in which a person gains a sense of connection and confidence, which increases their motivation to try, and attracts more positive attention from adults. This cycle repeats and reinforces itself as it progresses.

Based on their research in the area of resilience, Wolin and Wolin (1998) assert that they have focused on the specific behaviors or resiliencies that youth use to help themselves in times of trouble. Wolin and Wolin (1993) explain their rationale for this is that behaviors can be taught, modeled and learned. By defining the behaviors, they take the mystery out of resilience and provide concrete guidelines that youth can use as they struggle with the hardships in their lives. The most important part of a strength-based approach is the belief that youth in trouble actually have strengths and can act on them, although sometimes holding on to this belief is difficult. Wolin and Wolin (1993) further describe their definition of resiliencies as follows:

“Resilience” has been used to describe clusters of strengths that are mobilized in the struggle with hardship. According to Wolin and Wolin (1993), a vocabulary of strengths includes seven resiliencies: (1) insight: asking tough questions and giving honest answers; (2) independence: distancing emotionally and physically from the sources of trouble in one’s life; (3) relationships: making fulfilling connections to other people; (4) initiative: taking charge of problems; (5) creativity: using imagination and expressing oneself in art forms; (6) humor: finding the comic in the tragic; (7) morality: acting on the basis of an informed conscience.

Another project that had compelling results related to the process of tapping resilience comes from Mills (1993). His findings from pre- and post-evaluations of 142 families and 604 youth involved (during a three-year period) in Dade County, Florida public housing project include significantly improved parent-child relationships in 87 percent of the families, a 75 percent reduction in delinquency and school-related problem behaviors, a 65 percent decrease in drug trafficking, an 80 percent decrease in teen pregnancy, and a 60 percent decrease in substance abuse (Mills, 1993). The goal of the Health Realization Model is to "reconnect people to the health in themselves and then direct them in ways to bring forth the health in others. The result is a change in people and communities, which builds up from within rather than being imposed from without" (Mills, 1993, p. 35).

Resilience research has developed through the years and continues to offer many opportunities for further research. Thus, this investigation focuses on how the concept of resilience can be applicable to Mexican farmworker women, and further how sandplay therapy impacts MFW’s resiliency attitudes.

Summary

The review of literature presented in this chapter underscores the need for mental health services for Mexican farmworkers and specifically for women. This community has specific needs and challenges that are important to address through investigation and in the literature. Sandplay therapy has been one way of offering mental health services to populations who endure many obstacles and remain underserved. In addition, shifting the paradigm from pathology to resilience proves an effective methodology with many ethnic minorities and therefore seems quite appropriate to utilize when researching this population (Wolin & Wolin, 1993).

CHAPTER THREE: METHODOLOGY

The primary focus of this study is to examine the impact of individual sandplay therapy sessions on the participants' mental health status and resiliency attitudes. This chapter is divided into the following sections: (1) research design, (2) data collection procedures, (3) instrumentation, (4) statistical procedures, and (5) summary.

Sample

The participants of this investigation were forty Mexican farmworker women who live in rural central Florida and either work as farmworkers or are directly (marriage) related to individuals working in agricultural jobs. These women ranged from 18 to 45 years of age. They were randomly chosen from a total of 170 women who have had contact with migrant offices in public schools at the towns where they reside. A group of 20 women served as the control group who experienced a two-session model of treatment. The control group was given the option of participating in a program of 6 sessions after completion of the study. The second group of 20 women, the treatment group, participated in the 6-session model of sandplay therapy treatment.

The study was conducted at two migrant farmworkers' social service offices located at an elementary school and at a middle-high school in Central Florida. Proper consents through administrators of the programs and principals were obtained. These offices are located in two rural towns approximately ten miles apart from each other with similar sources of income in agriculture, specifically ferneries and citrus. All participants signed consent forms (Appendix A) in order to be a part of this investigation and were assured confidentiality of the information

given throughout the sessions. Participants were given a number in order to keep their identities confidential.

Research Design

A mixed research design was chosen to provide the necessary data for a more comprehensive analysis of sandplay therapy's impact on MFW's mental health and resiliency attitudes. The researcher believed in the importance of gathering quantitative data using assessments for mental health status and resilience attitudes. In addition, it was also important to gather patterns and themes that surfaced in sandplay sessions through qualitative data sources.

The intent of the present study is to investigate the impact sandplay therapy has on participants' mental health status measured by: (1) OQ-45, which assesses progress in therapy (Lambert, et al., 1996); and (2) Resiliency Attitudes Scale (R.A.S.), which determines resiliency attitudes (Biscoe & Harris, 1999).

The study also includes twenty participants' transcriptions of their individual sessions to illustrate the experiences of Mexican farmworker women with Sandplay therapy. The data gathered in the interviews and Sandplay therapy sessions was collected on audio and videotape, transcribed, and then analyzed for patterns and themes that emerged during sessions. Pictures were also taken of each Sandplay therapy session for further analysis and comparisons with the textual transcriptions.

Data was submitted to the process of triangulation, that is, the analysis and comparison of the verbal transcription of individual interviews, group interviews, and pictures of Sandplay sessions. In addition, two raters were used for the analysis of data in order to enhance the

reliability of the data analyzed. The second rater was a doctoral student in Counselor Education who has the same academic and clinical experience and training as the principal investigator of this study. Lastly, crystallization (the analysis of data from different perspectives) was utilized to render a deeper and more complex analysis of qualitative data (Richardson, 1994).

Procedures and Treatment Modalities

The control group completed the following model:

Session 1 – Focus group (1-2 hours). Group meeting to introduce the investigation (what, when, who, what, where about the project and its investigator). Complete forms for confidentiality and consent regarding the use of (participation, audiotape, videotape, and photographs of sandtray (Appendix A). OQ-45.2 Client Outcome measurement (Appendix B). The Resiliency Attitudes Scale resilience factors measurement (Appendix C).

Session 2 – Focus group (1-2 hours). Group meeting to finalize the investigation and complete forms for the resilience assessment inventory. The Resiliency Attitudes Scale (resilience factors measurement); OQ-45 Client Outcome measurement (mental health status measurement). Thus, the control group received no treatment.

The participants in the 6-session model (treatment group) completed the following:

Session 1 – Focus group (1-2 hours). Group meeting to introduce the investigation and complete forms: confidentiality and consent forms (participation, audio tape, video tape, and photographs of sandtray); The Resiliency Attitudes Scale (resilience factors measurement); OQ-45 Client Outcome measurement.

Session 2 – Individual session (1 hour). Individual introduction interview that included a

psychosocial history (Appendix D). The interview was semi-structured: the participants were asked to answer questions related to their psychosocial history.

Session 3 – Individual session (1 hour). Sandplay therapy experience. The investigator provided a traveling sandtray (19”x28”x3”) and different categories of miniature objects. Pictures were taken at that time and a copy shared with the participant.

Session 4 – Individual session (1 hour). Sandplay therapy experience.

Session 5 – Individual session (1 hour). Debriefing sandplay therapy session. Participants had the opportunity to discuss the sandplay experience.

Session 6 - Focus group (2 hours). Group meeting to finalize the investigation and to complete forms: resilience assessment inventory. The Resiliency Attitudes Scale (protective factors measurement); OQ-45 Client Outcome measurement.

In addition, a bilingual, bicultural mental health counselor and investigator conducted all meetings with participants of the investigation in Spanish.

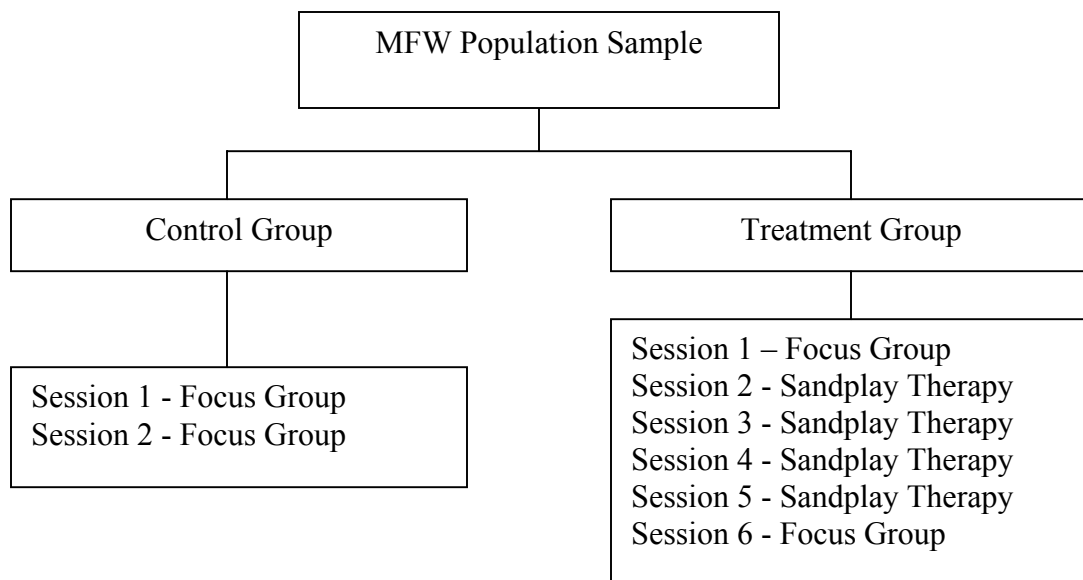


Figure 2: Treatment Modalities for Control and Treatment Groups in this Investigation

This investigation began in September, 2003 and ended December, 2003. The researcher allowed some flexibility in completing the 4 individual sessions as the population has difficulty with transportation and childcare. Further, MFW’s jobs restricted them to evening times where they were expected at home. Therefore, it was a real sacrifice for the participants (mothers) to leave home for one hour.

Conceptualization of Mental Health Status and Resiliency

In order to conceptualize both mental health status and resiliency a thorough research was done on applicable concepts for this kind of population. Client’s therapy outcomes were measured by the OQ-45.2 (Outcome Questionnaire) and resilient attitudes were measured via the Resiliency Attitudes Scale (R.A.S.). The participants of this study completed a pre-sandplay therapy resiliency assessment and post-sandplay therapy resiliency assessment. The conceptual definitions are provided in Chapter One what follows are details of the chosen assessment tools.

Instrumentation

Outcome Questionnaire (OQ-45.2)

The OQ-45.2 is a 45 item, self-report measure that is broadly applicable to adults in behavioral health treatment. It measures patient progress in therapy, and is designed to be repeatedly administered during the course of treatment and at termination. Patient progress is measured along three aspects of the patient's life that are monitored: (1) subjective discomfort (intrapsychic functioning), (2) interpersonal relationships, and (3) social role performance. These areas of functioning suggest a continuum covering how the person feels inside, how he or she is getting along with significant others, and how he or she is doing in important life tasks such as work and school. In addition, the OQ-45.2 was designed to be used as a baseline screening instrument with application for gross treatment assignment decisions. Specifically, the OQ-45.2 is available at low cost, sensitive to change over short periods of time, and brief, while maintaining high levels of reliability and validity. The OQ-45.2 is also designed to assess common symptoms across wide range of adult mental disorders and syndromes including stress related illness and v. codes (Lambert, et. al, 1996). The OQ-45.2 is also available in a Spanish language version.

Psychometric Properties of the OQ-45.2

Estimates of the test-retest reliability and internal consistency of the OQ-45.2 are based on data collected from two samples: undergraduate students (N=157) and individuals receiving services through employee assistance programs (EAPs; N=290); (Lambert et al., 1996). Internal

consistency estimates were calculated separately for the undergraduate and EAP samples. With respect to the undergraduate sample, coefficient alpha for the OQ-45.2 total score was .93, and was .92, .74, and .70 for the SD, IR, and SR subscales, respectively. With respect to the EAP sample, coefficient alpha for the OQ-45.2 total score was .93, and was .91, .74, and .71 for the SD, IR, SR subscales, respectively.

Lambert et al. (1996) used the undergraduate sample described above to assess the convergent validity of the OQ-45.2. The OQ total score and subscale scores were correlated with a number of commonly employed measures of anxiety, depression, social functioning, and interpersonal relationship functioning, to assess the convergent validity of the three theoretical domains of the OQ-45.2. The measures used for comparison were the Symptom Checklist-90-Revised (SCL-90-R), Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), Zung Self-Rating Depression Scale (ZSDS), Zung Self-Rating Anxiety Scale (ZSAS), Taylor Manifest Anxiety Scale (TMAS), Inventory of Interpersonal Problems (IIP), and the Social Adjustment Scale (SAS-SR). Results indicated that the OQ-45.2 correlated highly with the convergent measures. Correlation coefficients calculated between the OQ-45.2 total score and each of the measures ranged from .60 to .88. Among the subscales, the highest correlations were observed between the SD scale and the measures, with correlations ranging from .50 to .89.

Lambert et al. (1996), assessed the construct validity of the OQ-45.2 and examined the ability of the OQ-45.2 to demonstrate sensitivity to changes occurring in a consumer sample over time. The authors used a sample of 40 consumers receiving outpatient treatment. Pretest scores were compared to scores after seven sessions of therapy. Results of a repeated measures t-test indicated that the two scores were significantly different in the direction of improvement,

suggesting that the OQ-45.2 was sensitive to the types of changes resulting from therapeutic intervention. In addition, Lambert, Burlingame, and Umphress (1996) used hierarchical linear modeling to provide an additional investigation of the sensitivity of the OQ-45.2 to changes. Results were based on data collected from 1,176 consumers receiving therapy at outpatient mental health centers and a sample of 284 undergraduates who were not receiving treatment. All participants completed the OQ-45.2 on three occasions. Results indicated that the OQ-45.2 is largely sensitive to change based on the overall score as well as the three subscale scores.

Umphress, Lambert, Hansen, Lunen, Okiishi, Burlingame, Huefer, and Reisinger (1997) report additional findings in support of the construct validity of the OQ-45.2. This study utilized a sample of community members (N=210), consumers from a college counseling center (N=53), a community health clinic (N=106), and an inpatient psychiatric unit (N=24). An ANOVA was conducted to determine the ability of the OQ-45.2 to correctly discriminate groups as ranked from least to most severe. Results indicated that means of the patient and community groups differed in the expected directions, from inpatient (highest) to community members (lowest).

The authors reported additional support for the construct validity of the OQ-45.2 from the community clinic sample by investigating whether there were significant differences in the OQ-45.2 score between individuals with Axis I diagnoses and those with V-Code diagnoses. An independent t test supported this hypothesis for the OQ-45.2 total score and two of the three subscales, indicating that those with Axis I diagnoses had significantly higher OQ-45.2 scores than those with V-Code diagnoses.

Thus, the OQ-45.2 has a significant amount of empirical support for its psychometric properties. However, this body of research and the associated findings are not without

limitations. Mueller et al. (1998) call for additional empirical investigations of the factor structure of the OQ-45.2 and suggest that such studies may necessarily involve modification of the measure. The sample characteristics of each of the previously described studies are questionable with respect to generalizability. For instance, approximately 90% of each sample was Caucasian. This characteristic under-represents various ethnic groups routinely observed in clinical practice in many geographical locations. Likewise, the sample for a study by Nebeker, Lambert, and Huefner (1995) on ethnic differences on the OQ-45.2 was comprised of 86% Caucasians. While results were favorable, finding no ethnic differences, a more diversified sample is desirable, especially when investigating ethnic differences.

Resilience Attitudes Scale (R.A.S).

The Resiliency Attitudes Scale (R.A.S.) was developed to assess resiliencies as defined by Steven and Sybil Wolin in their book entitled *The Resilient Self* (1993). Items were developed to tap attitudes that would reflect each of the seven resiliencies the Wolin's identified while working with their clients: Insight, Independence, Relationships, Initiative, Creativity and Humor, and Morality. An additional subscale was added to assess general resiliency, which they defined as “persistence at working through difficulties, and belief that one can survive and make things better ” (<http://www.projectresilience.com/resilience.htm>). These resiliency subscales were further divided into "Skill Subscales" made up of questions that tap the basic resiliency skills within each resiliency. For instance, the independence resiliency requires that one be able to emotionally distance from unhealthy people, and to be able to recognize and end unhealthy relationships. To reduce response bias, approximately half of the questions were written so that

high resiliency would be indicated if the person agreed with the question and half the questions were reverse coded so that if the person disagreed with the question it would indicate high resiliency. The R.A.S is currently available in three versions: adult, adolescent, and child (Biscoe & Harris, 1999).

Psychometric Properties of R.A.S.

The validation process is presently ongoing. There is limited information of data gathered in a residential chemical dependency treatment center for women and their children consisting of $n=163$. All women completed both the R.A.S. and the Childhood and Adult Damage Inventories (Wolin & Wolin, 1993). The damage scale was taken verbatim from Steven and Sybil Wolin's book entitled *The Resilient Self* (1993). The damage scale has two subscales that assess perceptions of childhood and adult damage. Higher scores on the damage scale indicate more damage. Resiliency scores are negatively correlated with damage (-0.32, -0.49). In other words, women who scored higher in resiliency scored lower in damage. Correlations were highest between adult damage and resiliency. In addition, R.A.S. was correlated with depression and self-esteem, the sample consisted of 107 female residents of a residential chemical dependency treatment center for women and their children located in Oklahoma. All women completed the R.A.S., the Beck Depression Inventory (BDI) and the Rosenberg Self Esteem (SE) Scale. Higher scores on the BDI indicate more depression. Higher scores on the SE indicated higher self-esteem. Resiliency scores are negatively correlated with depression. This means that women who scored higher in resiliency scored lower in depression. Resiliency scores are positively correlated with self-esteem (.41, .21).

Materials

Participants in control and treatment groups individually completed OQ-45.2 and R. A. S. before and after the 6 treatment sessions.

Sandplay Therapy Materials

The investigator provided materials available for the participants at each session. The investigator provided a traveling sandtray (19"x28"x3") and different categories of miniature objects. Table 1 provides with a detailed list of the categories of the figures used in this investigation.

Table 1
 Categories of Sandplay Figures

Categories of Objects	Items
People	Peoples of various multicultural backgrounds; in recreational activities; in a variety of occupations; from the past and present; fantasy, mythological, and magical; fighting, warring, and enslaved; death figures; religious and spiritual people and objects; diverse races and cultures; body parts.
Animals	Wild animals of the land, sea, and air; domestic; extinct, mythological and fantasy; animal habitats; bones, shells, and feathers.
Plant life	Natural and artificial; complete plant life cycle
Minerals	Rocks; natural and artificial gems; marbles and beads.
Environments	Habitats of various cultures and areas; houses, mobile home, barn, church, fences and bridges.
Transportation	Land, water, and air; emergency and military vehicles.
Miscellaneous Objects	Planetary and earth symbols; objects that reflect and illuminate; medical symbols; aromatic objects; communication objects; containers; food objects.

Data Collection

This study also utilized twenty textual transcriptions of individual therapeutic sessions and focus group sessions with MFW to analyze and catalog for themes and patterns that emerged during sessions. The data gathered in focus groups and sandplay therapy sessions was collected in audio and videotape. These data were transcribed, catalogued, and analyzed for patterns and themes in the textual transcriptions as well as in the video and audiotapes. For the purposes of this study, and to better manage the amount of transcription and information, the investigator fully transcribed the first and last sessions with all participants. As the videotapes were reviewed and categorized, specific portions of the video tapes were later transcribed and translated. Audiotapes were used to support the quality of the transcription and translation. Tapes and photographs were viewed, rated and tallied by a second person, who is another doctoral student in the Counselor Education program at University of Central Florida with a similar professional background.

The investigator kept a fieldwork journal writing personal notes and thoughts during the investigation. In addition, the investigator wrote personal experiences essays weekly during the duration of the investigation. Fieldwork notes and reflections assisted in analyzing and categorizing and also served as sources for data through the triangulation process. Triangulation, the use of a variety of data sources in a study (Denzin, 1978), was utilized to catalogue and compare data.

All qualitative data utilized in this study went through the process of crystallization. Crystallization recognized the many facets of any given approach to the social world as a fact of

life (Richardson, 1994). “Crystallization provides us with a deepened, complex, thoroughly partial, understanding of the topic” (Richardson, 1994, p. 522). Data sources included transcriptions of individual interviews and focus groups and videos of sessions, which were analyzed and compared.

Statistical Procedures

A paired t-test was performed on the data gathered by the pre-test and post-test and compared. Paired t-test is used to compare means on the same or related subject over time or in differing circumstances. This statistical test assumes that the observed data are from the same subject or from a matched subject and are drawn from a population with a normal distribution. Subjects are often tested in a before-after situation (across time, with some intervention occurring such as a treatment). The paired t-test is actually a test that measures the differences between the two observations is 0. So, if D represents the difference between observations, the hypotheses are: $H_0: D = 0$ (the difference between the two observations is 0); $H_a: D \neq 0$ (the difference is not 0). The test statistic is t with $n-1$ degrees of freedom. If the p-value associated with t is low (< 0.05), there is evidence to reject the null hypothesis. Thus, you would have evidence that there is a difference in means across the paired observations. Based on the hypothesis the investigator tested if sandplay therapy is a counseling modality that impacted the clients' mental health and resilient attitudes.

Summary

This chapter presented a summary of the problem, the sample selection, data collection

procedures, the instrumentation description, as well as the statistical procedures. Chapter Four discusses the data findings and results.

CHAPTER FOUR: FINDINGS

Data Analysis

The quantitative and qualitative procedures used in analyzing data and obtaining results are presented in this chapter. First, the demographic profile of the participants in this population is presented. The second section addresses the statistical findings and the quantitative hypotheses. The third section in this chapter focuses on qualitative findings gathered from transcriptions of audio and video tapes from individual treatment sessions and photographs.

Demographic Findings

The participants of this study were 40 women who ranged from 18 to 45 years in age ($M=21.34$, $SD=6.53$). All were born in various states in Mexico and presently reside in rural Central Florida. From a population of $N=40$, 92.5% of these women are married. These women have 0 to 5 children ($M=2.45$). Seven (7) out of $N=40$ women have no children; 2 women have 1 child; 10 women have 2 children; 11 women have 3; 7 have 4 children; and 3 women have 5 children. These women are all Spanish speakers and first generation immigrants residing in the United States. They range from 7 to 17 years ($M=11.68$, $SD=2.89$). Their education ranges from 6th to 12th grade ($M=8.80$) levels of education. Thirty five percent have 6th grade, 5% have 7th grade, 22.5% 9th grade, and 27.5% 12th grade education. Table 2 presents the descriptive statistics about the participants in this investigation.

Table 2
Population's Demographics

	N Statistic	Range	Minimum	Max	Mean	Std. Dev.	Variance
AGE	40	27	18	45	31.34	6.533	42.680
STATUS	40	1	0	1	.93	.264	.070
CHILDREN	40	5	0	5	2.44	1.484	2.202
EDUCATION	40	6	6	12	8.80	2.442	5.961
U.S. YEARS	40	10	7	17	11.68	2.893	8.372
Valid N (listwise)	40						

Descriptive Statistics

Research Questions and Objectives Investigated

Mental Health Status: OQ-45.2 Findings

The first question this study addresses is the difference in MFW's mental health status after six sandplay treatment sessions. In order to determine if there is a difference in MFWs' mental health status after they participated in the therapeutic sessions, they completed the Outcome Questionnaire (OQ-45.2) at their first and last session in the study.

Null Hypothesis (1): There is no significant difference in MFW's mental health status after participating in Sandplay therapeutic sessions.

Alternate Hypothesis (1): There is a significant difference in MFW's mental health status after participating in sandplay therapeutic sessions.

Table 3 presents the findings from the paired samples t-test performed with the pre and post total scores of the OQ-45.2 in the treatment group. The paired samples correlations indicate

high correlation between pre and post-test ($n=.908$). The pre-test total score mean for the treatment group was $M=89.70$ with a standard deviation of $SD=16.9$; the mean total score for the treatment group's post-test was $M=73.70$ with a standard deviation of $SD=14.07$. A matrix of the means and standard deviations of the total OQ-45.2 scores of participants in the treatment group is provided in Table 3.

Hypothesis 1, which proposed that sandplay therapy sessions may impact mental health, was examined by a paired sample t-test. The results are summarized in Table 3. There was a significant difference between the means in mental health status of women in their pre and post-assessment ($t=9.92$, $df=19$, $p<.05$). Based on the paired sample t-test we accept the alternative hypothesis which states that there is a significant difference in Mexican Farmworker Women's mental health status after participating in sandplay therapy.

Table 3
Descriptive Statistics Pre and Post-Test OQ-45.2 for Treatment Group

	N	Minimum	Maximum	Mean	Std. Deviation
OQ45TX1	20	35	120	89.70	16.931
OQ45TX2	20	35	100	73.70	14.027
Valid N (listwise)	20				

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	OQ45TX1	89.70	20	16.931	3.786
	OQ45TX2	73.70	20	14.027	3.136

Paired Samples Test

		Paired Differences			t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		
					Lower	Upper	
Pair 1	OQ45TX1 - OQ45TX2	16.00	7.211	1.612	12.63	19.37	9.923 19 .000

Hypothesis 2 suggests that there is no significant difference in Mexican farmworker women's resiliency attitudes after participating in sandplay therapeutic sessions. To examine this hypothesis, resiliency attitudes total scores in pre and post-tests were compared utilizing a paired sample t-test. As shown in Table 4, the population was n=20 and the mean total score for R.A.S. in the pre-test was M=60.55 with a standard deviation of SD=4.6. The mean total score for R.A.S. in the post-test was M=63.85 with a standard deviation of SD=4.4. There is

significant difference in the means of the pre and post-tests ($t=-1.07$, $df=19$, $p=.05$). Thus, the alternative hypothesis is accepted which states that there is a significant difference in Mexican Farmworker Women’s resiliency attitudes after participating in sandplay therapeutic sessions.

An important finding within the seven scales in the R. A. S. is in the relationship scale. The mean score for the treatment group in the relationships scale in R. A. S. is $M=62.5$, compared to the analyses by race done by Biscoe and Harris (1999) (<http://dataguru.org/ras/dat/raceras.asp>) in a sample of female clients at a residential chemical dependency treatment center in Oklahoma. Biscoe & Harris (1999), found that African-American women scores in the relationship scale were $M=58.1$, Native American women were $M= 54.5$, and Caucasian women was $M= 54$. The implications of these findings are discussed in Chapter V.

Table 4
Resiliency Attitudes Scale Paired Sample t-test

Pair		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
1	RASTX1 - RASTX2	-3.10	3.243	.725	-4.62	-1.58	-4.275	19	.000

Paired sample t-test was also used to compare OQ-45.2 and R.A.S. total scores between treatment group and control group. Table 5 shows that the mean for the OQ-45.2 total score in

the post-test for the control group was $M=79.05$ compared to the total score for the treatment group $M=67.80$. Similarly, the mean total score in the R.A.S. post-test was $M=61.85$ for the control group and $M=63.65$ for the treatment group. The paired t-test indicates a significant difference between the mean score of the treatment group and the mean score of the control group ($t=-4.019$, $df=19$, $p=.05$). Therefore, the alternative hypothesis is accepted that states that there is a difference in the means of Mexican Farmworker Women's mental health status pre-test and post-test.

Table 5
Total OQ-45.2 Score Paired T-Test Treatment Group and Control Group

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	OQ45TX2	67.80	20	10.977	2.454
	OQ45CG2	79.05	20	9.622	2.151

Table 6

Total R. A. S. Score Paired Samples Test Treatment Group and Control Group

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	OQ45TX 2 - OQ45CG 2	-11.25	12.519	2.799	-17.11	-5.39	-4.019	19	.001

Paired samples statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	RASTX2	63.65	20	4.545	1.016
	RASCG2	61.85	20	6.046	1.352

Paired samples t-test control and treatment groups R. A. S.

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	RASTX2 - RASCG2	1.80	7.008	1.567	-1.48	5.08	1.149	19	.265

The fourth question posed in this study examines the themes and patterns that sandplay therapy uncovered when working with MFW. The findings were gathered and analyzed from text transcriptions based on audio and videotapes of focus group sessions and individual

treatment sessions. The cataloguing of the transcribed text from the audio and video sessions was reviewed through triangulation process. First, the researcher identified words and phrases related to women’s mental health that were most often used in individual sessions and are presented on Table 6. In addition, the investigator’s journal, fieldwork notes, and fieldwork reaction essays were also used in data triangulation, the use of a variety of data sources in a study (Denzin, 1978).

Table 7
Phrases Most Frequently Used in Sandplay Sessions

Topic	Sessions					
	1	2	3	4	5	6
Anger – <i>Enojo</i>	60	49	10	30	26	28
Loneliness – <i>Me siento sola</i>	74	45	33	15	25	18
Depression – <i>Estoy triste, siento tristeza</i>	40	38	40	17	9	16
Anxiety – <i>Sufro de nervios, tengo nervios</i>	36	40	32	22	12	19
Mood Swings – <i>Me pongo alterada, me altero</i>	54	34	77	11	22	33
Stress – <i>Siento presión, estoy tensa</i>	49	22	15	29	19	27
Communication – <i>No hablamos, no me habla</i>	86	89	33	47	42	34
Total	399	317	240	171	155	175

1, 2, 3, 4, 5, and 6 are the sessions that the control group experienced.

Secondly, the textual transcription of the control group’s focus group sessions was analyzed. Table 7 shows in detail that these women had similar mental health concerns as the participatory group.

Table 8
Phrases Most Frequently Used in Focus Group sessions

Topic	1	2	3	4
Anger – <i>Enojo</i>	40	39	30	35
Loneliness – <i>Me siento sola</i>	35	45	50	48
Depression – <i>Estoy triste, siento tristeza</i>	40	38	40	33
Anxiety – <i>Sufro de nervios, tengo nervios</i>	36	40	32	35
Mood Swings – <i>Me pongo alterada, me altero</i>	34	34	37	21
Stress – <i>Siento presión, estoy tensa</i>	29	22	15	23
Communication – <i>No hablamos, no me habla</i>	55	43	39	37
Total	269	261	243	232

1, 2, 3, and 4 are focus group sessions

Transcriptions of individual and group sessions also rendered important trends regarding MFW’s psychosocial history. Table 8 indicates some participants’ reported having been victims of sexual violence in their lifetime. Out of a total forty participants, twenty five reported having been victims of sexual violence in their lifetime and fifteen reported no history of sexual violence. This represents 62.5% of the women who participated in this investigation reported a history of sexual violence sometime in their lifetime. Figure 3 represents a bar graph diagramming the percentages of women who reported having been victims of sexual violence in column 1 and women who did not report a history of sexual abuse in column 0.

Table 9
Reported Sexual Violence During Their Lifetime

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	15	37.5	37.5	37.5
	1	25	62.5	62.5	100.0
	Total	40	100.0	100.0	

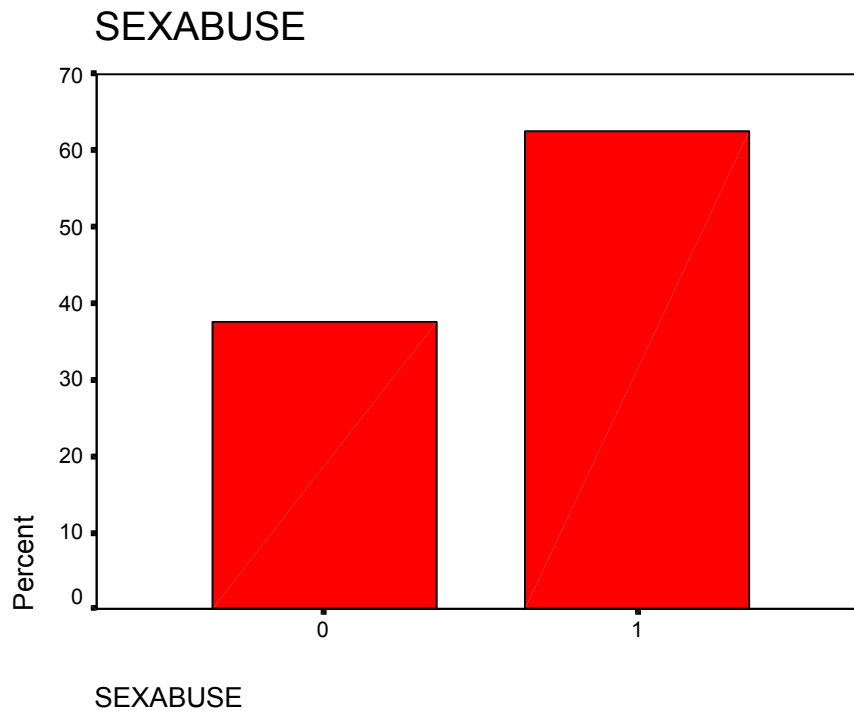


Figure 3: Reported Sexual Violence During Their Lifetime

Another finding uncovered in this study is the history of domestic violence. Findings report that 95% of the women who participated in this investigation reported history of domestic

violence sometime in their lifetime. That is, from a total of forty participants, thirty-eight reported history of domestic violence and two participants did not. Detailed findings are shown in table 9 and a bar graph illustrates these findings in Figure 4.

Table 10
Frequency Table of Reported History of Domestic Violence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	2	5.0	5.0	5.0
	1	38	95.0	95.0	100.0
Total		40	100.0	100.0	

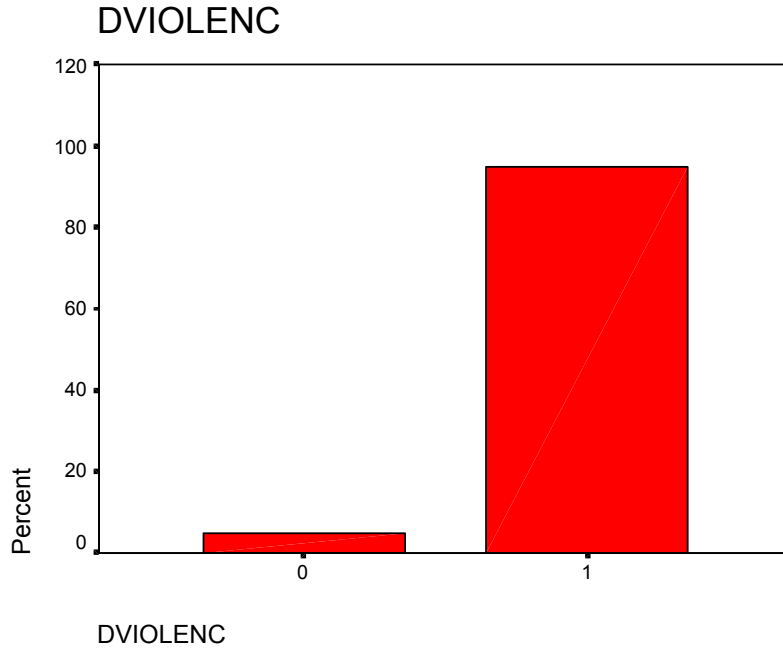


Figure 4: Percentages of Reported History of Domestic Violence

Data was also categorized in terms of recurrent themes of resiliency and strength. The text transcriptions, presented in Table 10, point into very specific themes that these women voiced in their individual sessions.

Table 11
Resilient Phrases Most Frequently Used in Sessions

Topic	Number
Children – <i>mis hijos, mis chamacos</i>	728
Religion – <i>la iglesia, el grupo de la iglesia, el padre</i>	464
Friends – <i>mis comadres, el grupo de la iglesia</i>	573
Family – <i>la familia</i>	357
General resilient thoughts: <i>hecharle ganas, hay que tener fé, siempre hay esperanza</i>	378
Total Number of times voiced in sessions	2506

Finally, the investigator used photographs and video rating to explore the last question posed in this study regarding resilient images that farmworker women uncovered in sandplay therapy. These data uncovered figures that were most often used in sandtray sessions. The results are displayed in Table 11.

Table 12
Resilient Images Most Frequently Used in Sandplay Sessions

Image / Figurine	Number
Children / family	240
Houses	240
Ferns	230
Trees	235
Rocks	180
Butterflies	120
Fences	124
Total	1245
Number of times this item was presented in sandtrays	

Summary

This chapter presented the findings gathered from quantitative and qualitative data. First, paired sample t-tests of OQ-45.2 and R. A. S. comparing pre- and post-tests were presented. Secondly, paired sample t-tests comparing treatment group and control group were noted. Lastly, findings of qualitative data were listed.

CHAPTER FIVE: CONCLUSION

This chapter discusses the results of this investigation and implications for use of sandplay therapy with Mexican farmworker women. In addition, there is consideration for future research and a discussion regarding certain limitations of the study.

Discussion of Results

Population

In this study we have uncovered specific obstacles and strengths unique to Mexican farmworker women that directly impact their mental health status and resiliency attitudes. As first generation immigrants working in agricultural jobs, this population reportedly experienced many obstacles in their lives. For example, many of the women reported a history of sexual and domestic abuse, the need for managing depression and anxiety, and the need for coping with strict adherence to gender roles within couples. Moreover, this study also uncovered themes of resiliency and strength that impact MFW's mental health, including family, children, religion, church support group, and friends. Three categories of themes that surfaced in the findings are important to address: (1) history of sexual violence and domestic violence; (2) mental health concerns relative to loneliness, depression, & anxiety; and (3) social networks and religion as sources of resilience.

Sexual and Domestic Violence

Although alarming, the findings regarding Mexican farmworker women's history of

sexual and domestic violence are not surprising. Sexual and domestic violence against women are two of the most devastating and traumatic issues that women confront around the globe. This population follows the unfortunate global trends. Worldwide, at least one in three women and girls has been beaten or sexually abused in her lifetime (UN Commission on the Status of Women, 2000). It is also reported worldwide that one in three women have experienced some form of abuse by an intimate partner or family member at some point in their life (Population Reports, 1999). In addition, a recent study of women in the U.S. by the Commonwealth Fund (1998) indicated that 31% of women reported being kicked, hit, punched, choked, or otherwise physically abused by an intimate partner during their lifetime. More than 3 million women (3%) reported experiencing domestic violence within the past year (Commonwealth Fund, 1998). Although battered Latina women have been the focus of research on topics such as battering during pregnancy (Campbell, Torres, Ryan, King, Campbell, Stallings, & Fuchs, 1999; McFarlane, Wiist, & Watson, 1998), sexual abuse (El-Bassel, Gilbert, Krishnan, Schilling, Gaeta, Purpura, & White, 1998; Lira, Koss, & Russo 1999; Dávila & Brackley, 1999), and barriers to use of services (Bauer, et al., 2000), Mexican farmworker women have not been identified in the samples of these studies.

Despite some attention in recent years to domestic violence among migrant farmworker women, research on domestic violence among this population continues to progress at a slow pace and much is still unknown. While understanding of domestic violence in the general population grew considerably during the 1970's and 1980's, it was not until the mid-1990's that migrant and seasonal farmworker women were included in subjects of, and participants in, research in this area. Most studies have focused on documenting the problems facing these

women. In general, prevalence studies (e.g., Rodriguez, 1998), using non-random samples of migrant or seasonal farmworker women, have reported that 20% of women experienced physical abuse and 10% reported forced sexual activity in a one year period.

The California Agricultural Worker Health Survey (1998) found that overall, 5% of female farmworkers had been the victims of violence in the previous twelve months of the survey. In one particular site, 14% of women reported being physically abused in the previous year. The high variability demonstrated across sites is a likely indication of underreporting.

More recently, Van Hightower, Gorton, and DeMoss (2000) examined the prevalence and predictors of domestic violence in a large nationwide sample of migrant farmworker women. They found that 19% of the women reported being physically abused in the past calendar year. Within this 19%, one-fourth of the women reported also being sexually abused. In terms of predictors, they found that migrant farmworker women were 47% more likely to be abused than seasonal farmworker women; that women whose partners used drugs and/or alcohol were six times more likely to be abused; and that pregnancy decreased the probability of abuse by 65%.

The high percentage of women reporting sexual and domestic abuse in this study accounts for specific reporting. First, most studies cited above reported percentages of women being abused in the last year. Women in this study reported sexual and domestic abuse throughout their lifetime. Secondly, the high variability of reporting illustrates how different ways of investigating domestic violence render different statistics, yet one thing remains clear: sexual and domestic abuse in MFW goes underreported and there is a need for further investigation.

The mental health consequences of domestic violence cannot be overlooked. Studies

have shown that 29% of women who were battered attempted suicide, 37% had symptoms of depression, 46% had symptoms of anxiety disorder, and 45% experienced post-traumatic stress disorder (Danielson et al., 1998). Therefore, it is important to note that since these studies have not specifically identified or included Mexican farmworker women, the specific health effects of domestic violence on this population remains unknown.

Mental Health

One of the findings in this investigation focused on the mental health status of Mexican farmworker women measured by OQ-45.2. The OQ-45.2 (Outcome Questionnaire) measures patient progress in therapy, and was administered before treatment and at termination. Patient progress is measured and monitored along three aspects of the patient's life: (1) subjective discomfort (intrapsychic functioning), (2) interpersonal relationships, and (3) social role performance. As presented in the findings section, there is a significant difference found in the participant's mental health status after treatment. This finding certainly provides strong evidence to support creative therapeutic programs to serve this underserved population.

As reported in Table 7 of the findings section, women reported loneliness, depression, and stress. Although relatively little is known about the prevalence of depression among migrant farmworkers, three former studies measured depression through the use of the Center for Epidemiologic Studies Depression Scale (CES-D). Typically, approximately 18% of individuals who completed the CES-D displayed significant risk for depression. DeLeon Siantz (1990a) measured the prevalence of depression among Mexican migrant mothers in Texas. She found that 41% of the mothers fulfilled depression diagnosis according to DSM-III. Hovey, Rojas,

Kain, and Magaña (1998) reported that 38% of their sample of Mexican migrants in Michigan and Ohio reached a heightened risk for depression. Contrary to these high depression levels Alderete, Vega, Kolody, and Aguilar-Gaxiola (1999) reported that 20% of Mexican migrant farmworkers in Fresno County, California reached depression diagnosis.

Because Mexican culture traditionally emphasizes familism, collectivist values, and affiliation. Mexican migrants may be particularly vulnerable to depression when they lack support from family and friends. In fact, the standard level of depression found in Alderete et al.'s (1999) sample might partially result from the migrants' overall access to the available support network in the Fresno area. Not surprisingly, therefore, Alderete et al. (1999) found that those migrant farmworkers who indicated high levels of instrumental and emotional support reported lower depression. Hovey et al. (1998) and De Leon Siantz (1990a) reported a similar relationship between positive emotional support and lower depression among Mexican migrants in Michigan, Ohio, and Texas.

Furthermore, researchers have documented that high levels of depression among migrant farmworkers are associated with high acculturative stress (Hovey & Magaña, 2002a), low self-esteem (Hovey & Magaña, 2000b), discrimination (Alderete et al., 1999), lower income (White-Means, 1991), physical health problems (Vega et al., 1985), and lack of child care (De Leon Siantz, 1990a). Although the studies above provide information on depression among migrant farmworkers in general, there are no specific studies done with Mexican farmworker women. This indicates the need for additional studies that specifically address Mexican migrant farmworker women as they have unique stresses and pressures differing from the general migrant farmworker population.

Another important finding worth from this investigation is that the control group also experienced a small level of improvement in their OQ-45.2 total scores. The counselor/client relationship has to be considered as a contributing factor on the findings. This population has had no access to a counselor and the fact that there was a person interested in them and sharing time with them made this population express its gratitude and certainly might have been a contributing factor in the results. This illustrates the value of engaging and interacting with this population and the positive impact it can have. In regards to the applicability and validity of the OQ-45.2 with this specific population, this assessment instrument was an effective tool for the measurement of mental health status with MFW.

Resiliency

The length of the R. A. S. (70 items) was certainly an obstacle for this population. After completing OQ-45.2 (45 items), completing R. A. S. (70 items) seemed daunting for this population. With individual assistance the participants were able to complete the R. A. S., but fatigue potentially impacted completion of this assessment. Considering that this population's mean education is 9th grade, and that there is some evidence printed materials are not the best source to engage this population (Hovey et al., 1998), there may be other resiliency assessments that should be investigated for this specific population.

The findings support that a difference exists between the means in the treatment group and the control group in resiliency attitudes. R. A. S. scores in the relationship scale $M=62.5$ evidence a theme reported by MFW and that it is the support they receive by their social networks including their families, friends, and religion.

The process of crystallization was important in data analysis for this study. Crystallization recognized the many facets of any given approach to the social world as a fact of life (Richardson, 1994). “Crystallization provides us with a deepened, complex, thoroughly partial, understanding of the topic” (Richardson, 1994, p. 522). Crystallization, without losing structure, deconstructs the traditional idea of “validity” (there is no single truth, text validating themselves). In traditional research, triangulation was valued to “validate” findings. However, triangulation carries the same domain assumptions, including the assumption that there is a “fixed point” or “object” that can be triangulated. But in postmodernist mixed-genre texts, crystallization is preferred. Recognizing that there are far more than “three sides” from which to approach the world. Thus, the central imaginary for validity for postmodernist texts is not the triangle—a rigid, fixed, two-dimensional object. Rather, the central imaginary is the crystal, which combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angle of approach (Richardson, 1994). Crystals grow, change, alter, but are not amorphous. Crystals are prisms that reflect externalities and refract within themselves, creating different directions (Richardson, 1994).

Resilience: Social Networks and Religion

Through the transcripts of individual sessions there were important themes that were voiced by Mexican farmworker women as sources of resilience. Social networks and community was a recurrent theme expressed by the participants as a source of support and resilience. Although as noted earlier, there is not a word for resilience in Spanish; therefore, they utilized the word support [apoyo]. Research on families and community resilience in Latin America has

shed light on the importance of relationships and “solidarity” as an integral part of how people live in countries such as Colombia (Hernández, 2002). In Hernández (2000) study with Colombian residents living under violence of the guerilla war she finds that the term solidarity becomes important in the construction of resilience as a concept. Studies on social network by Abello and Madariaga (1992) have addressed the function of social networks in communities living in poverty. They viewed it as a survival mechanism when people need emotional, moral, social, and economic support. They found that people develop relations of “compadrazgo” (a word that people use to refer to other who are close and are considered part of the kinship although biological ties do not exist. These relationships develop over time as people share their daily lives through socializing and helping each other. These relationships are based on trust and reciprocity.)

The notion of hope within networks of social relationships is a key feature of importance in Latin American mental health responses to trauma (Lesner, 1996). In these approaches, hope lies in the promotion of social change through community, therapeutic work, and advocacy. The concepts of trauma and hope and processes of recovery are considered mutually dependent and embedded in the ethos of communities (Hernández, 2002).

Hernández (2002) conceptualizes resilience as collective and ingrained within relationships in communities by illustrating the wholeness of communities and understanding how people care for each other. She concludes that Latin American ways of coping with adversity have a community dimension that can be best described by the term solidarity. When used in Spanish language, this word encompasses patterns of activity related to making meaning out of surviving at the community level.

The social network existing in these communities entail interpersonal threads that compose the social fabric of communities facing oppression. This interconnectedness brings in both the challenges of strains in interpersonal relationships and the reassurances and strengths of being able to share and rely on people. The meaning of solidarity is ingrained in the social fabric and ways of caring of these communities. The following are excerpts from the life stories of MFW illustrating the community dimension of resilience.

Spanish text: Después que mi comadre me escuchó, me dió un abrazo y me preguntó que cuando me iba a dar tiempo para mí... me dijo que tengo que dejar de ser tan orgullosa y que el mundo no se acaba si yo no voy a trabajar un día. Después me dijo, si te quedas en casa hoy y no vas a trabajar seguro que cuando regresas harás mejor tu trabajo. Yo estaba bien enferma y quería ir al doctor ese día. Ella se encargó de mis hijos, de la cena, y me hizo sentir como si tuviera mi familia. Esa es mi comadre... sabe?

English Translation: After my 'comadre' listened to me, she hugged me and asked me when was I going to give myself a break... she told me to let go of my arrogance and that the world will not end if I had to be absent for one day at work. She said if you stay at home when you get back to work you'd do a better job. I was very sick and needed to go to the doctor that day. She took care of my kids, dinner, and made me feel like I had family with me. That is my comadre for you... you know...

Another example of the importance of friendships and the nature of solidarity within Latino communities is illustrated by one of the participant's experience. When told by the

doctors that she needed dialysis, she shared that her strength to endure her illness came from her group of friends at church and the appreciation she felt for having them as her support.

Spanish text: Yo les conocí a mis comadres en la Iglesia, en seguida que nos mudamos acá. Yo ya estaba mala con la enfermedad, pero yo no le decía a nadie porque necesitaba trabajar. Pero me puse más mala con la enfermedad, y las personas en la Iglesia se dieron cuenta y llamaron a mi esposo y a mí. Ellos nos ofrecieron su apoyo sin saber que grave estaba yo y cuando me puse más mala estas personas se convirtieron en mi familia. Ellas se encargaron de mis hijos, de darnos de comer, y cuando me fuí al hospital ellas cuidaron la casa. Ni mi familia en México hicieron todo lo que ellas hicieron. Mis amigos de la Iglesia me dieron esperanza y yo me dí cuenta también que hay otras personas en peores condiciones que yo.

English translation: I met my ‘comadres’ at the church after we moved here, I was becoming ill, but I told no one about it because I needed to work. As I got worse, people at church noticed and called my husband and me. They offered support not knowing the gravity of my illness and as the illness got worst these people became my family. They took care of my kids, they brought food, and since I was in the hospital for some time they took care of the house. Not even my family in Mexico would do this for me and this people did. My friends at church give me hope and I realize that others have it worst than I do.

Another aspect of Mexican farmworker women’s solidarity, care, and affection is hope.

Participants emphasized the idea of hope in the context of their faith and religious convictions:

Spanish text: Yo tengo esperanza por medio de mi fé. En la manera que yo me relaciono con la vida de Dios, en mi historia, apoyada en oraciones y en la Biblia. Pero otra de las cosas que me ayudan a tener esperanza son mis amigas de la Iglesia. Saber que puedo contar con ellas... que puedo hablar y compartir mis sentimientos....

English translation: I get hope from my experience of faith. In the manner in which I relate to God's life, in my history, supported in my prayers and Bible readings. But another thing that helps me is my friends at church. Knowing that I can count on them... that we can talk and share our feelings...

The community dimension of solidarity is salient in the stories above. These relationships and solidarities that people build over time are at the heart of the building of supportive networks to survive. Understanding the language used in the Mexican farmworker community to refer to coping with adversity has valuable theoretical and therapeutic potential. An expanded understanding of resilience is possible when integrating the concepts of community, hope, and solidarity. This integration may be accomplished by introducing the concept of collective resilience.

Future research should focus on finding appropriate assessment tools for measuring resilience in this population. Assessment tools that address the integration of the concept of collective resilience, solidarity and hope are very important when future investigations on resilience are done with Mexican farmworker women population.

Sandplay

Through sandplay Mexican farmworker women found their voice, uncovered their concerns, and discovered some of the resilient qualities they possess. In discussing the findings regarding sandplay there are various figurines and representations that surfaced consistently during sandtray sessions with this population (Table 10, Chapter IV). These figurines fall under two major categories: (1) family: (a) children; (b) people; (c) houses; (d) fences and (2) Nature: (a) plant life: flowers, plants, & trees; (b) animal life: butterflies; (c) rocks, stones.

Jung developed the technique of symbol amplification. It consists of adding to the client's associations to a symbol by looking into mythological, religious, and folk tale representations of similar material. With adults, this can be explored consciously, both therapist and client delving into the material in depth. The discussion of specific symbols that follows is not meant to be used in an absolute or reductive way, but as an aid in seeing some of the potential meanings that occurred in the process of sandtray work with MFW. The power of the object to attract the attention of the client's consciousness must not be diluted by an absolute interpretation. The process is best served by not speaking of these meaning, but rather just containing this awareness. Jungian symbolist and Sandplay therapists who have interpreted these figurines offer some interpretations to the various categories used most often by Mexican farmworker women in this study.

Family

In regards to family, Jungian symbolism points to various interpretations of children, men, houses, and fences (some of the items most utilized by participants in sandtray). Following

are some interpretations that were helpful when thinking about the sandtrays women created.

A child is an archetype of the self uncontaminated with personal problems and concerns (Steinhart, 2000). Many images of children remain in our memories: the playful child, mischievous child, curious child, the happy and carefree child, innocent child, and the lonely child to name a few. Like the unconscious itself, the child is an embodiment of possibilities (Steinhart, 2000).

The common archetypal masculine images are those of the Hero, the Wise Old Man, the Father, and the Son. Heroes are expected to be loyal friends, but the principle is associated with law and order, reason and consciousness, and the spiritual (Perkins McNally, 2001).

The house is associated with the human body. Houses are usually interpreted as symbols of the self; one's inner being. Dreams parallel this symbolism. The house represents the conscious and unconscious state of the subject. The type of house chosen is reflection of the person's present state. A house may also represent the sheltering of the archetypal mother, the family, and security (Perkins McNally, 2001).

An example of an interpretation of fences comes from Bradway, Signell, Spare, Stewart, and Thompson (1990) who write about the use of fences in sandtrays as it coincides with the client's emerging ability to confront and to be confronted by the outer forces of culture. This is one of Kalff's stages in sandplay therapy and describes a stage of adaptation to the collective. Sources of energy often appear during the period of transition. It is as if the ego needs an additional supply of energy in order to cope with the struggle between inner and outer forces. Also indicating an attempt to make connections between opposing parts of one's self; the good and the bad, the passive and the aggressive, the grown-up self and the baby self, the compliant

and rebellious, the masculine and feminine.



Figure 5: Sand Tray 1

In this study, participants interpreted their own sandtrays and to better present how MFW experienced sandplay it is important that they themselves voice their experiences. Therefore, following are vignettes extrapolated from individual sessions where women discussed their interpretations of some of the figurines listed on Table 11. Participant 1 explains the meaning of one of her sandtrays.

Spanish text: Investigator: Haber explícame, esto representa tu mundo, sí?

Participant: Esta es mí casa, esa es una mariposita, ahí para que le dé el toque femenino. bonito... Con cerca, bueno la mía no tiene cerca pero me gustaría poner una cerca; y los árboles, tengo árboles, me gustan las plantas, las flores, piedras, un carro. Este es mi

esposo, soy yo, un monito de los que tengo en mí casa, de los que me regaló mi esposo. Este es Juan, José, Carlos y Esteban. Y tengo la pelota de fútbol que es lo que nos gusta a todos; y eso lo que es mí mundo.

Investigator: Y esta figura que te representa, como se siente en su mundo?

Participant: Bien, rodeada de lo que le gusta. No más que para mí gusto le hubiera puesto una cerca mas grande. Me gustaría que tenga [una cerca] alrededor de toda la casa.

Investigator: Cuál es el propósito de cercar la casa?

Participant: Para sentirme más segura. Sí, más segura porque en el pasado un muchacho se quiso meter y si me gustaría estar más segura. Mis chiquillos también podrían jugar atrás y no me preocuparía.



Figure 6: Sand Tray 2

English Translation: Investigator: This represents your world, right?

Participant: Yes, this is my house. That is a butterfly, so that there is the feminine touch, beautiful... With a fence; well, mine doesn't have a fence, but I would like to have a fence; and the trees, I have trees. I like plants, flowers, stones, and a car. This is my husband. This is me and a teddy bear one of those that have at home, one of those that my husband gave me. These are my children, Juan, José, Carlos, and Esteban. And there is a soccer ball...that is what we like to play; and that is my world.

Investigator: This figure that represents you, how does she feel in her world?

Participant: Well, surrounded by what she likes. The only thing is that I would like to put a fence around my home. I would like a fence around the whole house.

Investigator: Why would you like to fence your house?

Participant: To feel secure. Yes, secure because in the past a man wanted to break in and if I would have a fence I would feel more secure. My children could also play in the back and I wouldn't have to constantly worry.

This excerpt of the transcription of the session illustrates how through sandtray, participants were able to see and interpret their world. In this example, the discussion focuses on her family and her concern for their security. She also speaks about her positive outlook of her world with her family.

Nature

Utilizing plant life in sand tray has various meanings according to some experts (Perkins McNally, 2001; Jung, 1959). The single tree is representative of the psyche's power to connect

the various elements or states of consciousness (Perkins McNally, 2001). The tree is rooted deep within the earth, in the darkness and unknown. It draws water and nutrients into itself from the earth, and it has its branches in the heavens. In this sense it symbolizes the joining of the worlds of the physical, emotional, and mental life, and connects the visible with the unseen. In ancient thought the tree connects the feminine, receptive earth with the masculine sun and air (Perkins McNally, 2001). In addition to representing the Self, the tree may represent the Mother archetype (Jung, 1959). It serves to shelter, protect, and nourish, and in these ways is a symbol of the feminine principle. Its strength and uprightness appear to be masculine characteristics. In these ways, the tree can symbolize the androgynous qualities of the psyche (Jung, 1959).

The Biblical Tree of Life represents spiritual life and understanding as opposed to carnal, fleshly life without spiritual understanding. The Judaic understanding is that the Tree of Life represents the Torah. The Biblical Tree of Knowledge of Good and Evil represents the necessity to make moral choices in life, yet apart from God we fail to obtain the results we desire (Jung, 1959).

According to Jungian symbolism experts (Steinhart, 2000; Perkins McNally, 2001; Bradway, 1990), the inclusion of plantlife seems to be related to an inner sense of potential for psychological growth, in contrast to the starkness of sand worlds that connote feelings of lifelessness. The use of one or more trees in a sandtray can be interpreted as the symbol of growth and of life. In counseling, this idea can be used to validate clients and illustrate how befitting this metaphor is in counseling as clients undergo a process of growth and transformation. According to Steinhart (2000), most flowers are characterized by openness, color, softness, vulnerability, receptivity, and fragrance. Associations with the feminine

principle are unmistakable (Steinhart, 2000).

The concern for nature was certainly an important theme in the participants' sandtrays. Following are small vignettes illustrating the participant's interpretation of their use of flowers, butterflies, and rocks on their trays. These figures were interpreted by participants as sources of strength in their worlds.



Figure 7: Sand Tray 3

Spanish text: Investigator: Qué representan las flores?

Participant: Personalmente, las flores me gustan porque como que siento que me dan fuerza. No como un poder mal adquirido, pero no sé... como que purifica el ambiente el tener árboles, me siento más protegida no sé porqué? me siento más protegida cuando estoy cerquita de un árbol; en vez de cuando estoy en un lugar pelón. No sé porque? me

gusta estar rodeados de ellos porque siempre me fascinaron. Siempre fue una niña que me subía a los árboles. Ahora, pues ya no me subo, pero sí me gusta tenerlos porque me siento en lo mío en mi entorno.

Investigator: También te gustan las flores?

Participant: También me gustan las flores, nada más que no se me dan muy bien. Pues, he batallado muchos años con tener flores en la casa. Pero yo pienso, pero tal vez es idea mía...que tal vez las flores no se me dan por mi sentido de ánimo.

Investigator: Aha.

Participant: Planto una flor cuando estoy triste y no se dan, se marchitan. Y cuando estoy contenta sí se dan. Y luego platico con ellas... siempre me han gustado las flores.

English Translation: Participant: Personally, I like flowers because I feel like they give me strength. Not like a power that is not deserved, but I don't know... is like it purifies the atmosphere having trees; I feel more protected I don't know why? I feel more protected when I am close to trees, rather than when I am in a barren place. I am not sure why I like to be surrounded by trees... they have always fascinated me. When I was a young girl I loved to climb on trees. Now, I no longer climb on them, but I like to have them around me to feel in my environment.

Investigator: Do you also like the flowers?

Participant: I also like the flowers, but I can't grow them very well. I have battled many years trying to grow flowers in the house. But I think, but perhaps it is just my idea...that perhaps the flowers don't grow because of how I feel.

Investigator: Aha.

Participant: If I plant a flower when I'm sad they don't grow, they wither. And when I am happy they grow beautifully. I also chat with them... I've always liked flowers.

Animals are interpreted as being representative of instinctual and emotional urges. Jung (1956) believes that animals are representative of non-human aspects of the psyche. Animals can also represent poorly integrated aspects of the self, old memories (Jung, 1956). A butterfly symbolizes miraculous power of transformation, change, joy, and immortality. The lowly caterpillar is transformed into a graceful winged creature that, like birds, inhabits the air. Associations are with spiritual transformation (Perkins McNally, 2001).



Figure 8: Sand Tray 4

Spanish Text: Investigator: Háblame de la mariposa.

Maria: Bueno, por lo menos mí casa. Que se vea que vive una mujer ahí. Las mariposas siempre se me han hecho... si son así de colores bonitos..... sí, son muy bonitas. Muy femeninas, frágiles, se me hacen como muy frágiles pero también fuertes poque pueden volar. También la transición de una cosa chiquita y fea a una cosa bonita.



Figure 9: Sand Tray 5

English Translation: Investigator: Speak to me about this butterfly.

Participant: Well, at least in my house... I like people to see that a woman lives there.

Butterflies have always been ... if they have beautiful colors..... yes, they are very beautiful. Very feminine, fragile, they are made fragile, but also strong because they can fly. Also, the transition of a tiny and ugly thing to a beautiful thing.

In the past a stone, tree, mountain, or groves were understood as symbolic of the cosmos

(Cirlot, 1962). Pillars or tall stones were considered to represent an axis mundi, or point of entrance to different levels of consciousness. Stones are seen to be a symbolic being and reconciliation with self (Perkins McNally, 2001). Common associations are strength, durability; permanence, imperishability, integrity, and immortality (Steinhart, 2000). The Rock of Gibraltar typifies this usage. Standing stones are associated with the sacred, and the life force.

Cirlot (1962) associates stones “fallen from heaven” with the origin of life. In volcanic eruptions, air turned to fire; fire became water and water change to stone. Meteorites and other stones that contain black pigment were worshipped, for example, the black stone of Pessinus, and the Kaaba in Mecca (Cirlot, 1962).

Spanish text: Investigator: Cuéntame de las piedras.

Participant: Siempre me han gustado las piedras. Y más cuando uno las puede recoger. Bueno, hay piedras en la casa grandes que uno se puede sentar ahí. Las usamos de silla, me gusta el contacto que tenemos con la tierra. Me gusta verlas, si pudiera poner piedras en lugar de bancas se me hace bonito. Se me hace que uno tiene que tener piedras en la casa por cualquier cosa, ha, ha! por si acaso. . . sí, se me hace bien interesante porque desde chiquita jugaba hasta matatena con piedras.

Investigator: matatena es el juego con una pelotita y jacks?

Participant: Sí, nada más que aquí le hacen con esas cositas. Nosotros las jugamos con piedras.

Investigator: Donde vivías en México habían lugares con piedras?

Participant: Sí donde yo me crié hay piedras grandes y uno las pone en el jardín como

muebles para sentarse y uno plastica. Las piedras me traen buenos recuerdos.



Figure 10: Sand Tray 6

English translation: Investigator: Tell me about these stones.

Participant: I have always liked stones. And even more when one can pick them. Well, there are big stones in the house the ones that you can sit on them. We use them as chairs. I like the contact that we have with the earth. I like to see them, and if I could I would have an outdoor living room just out of stones they are so beautiful. I believe that is great to have stones around the house just in case...laugh.... Just in case...Really, stones are really interesting because even when I was small we use to play “Matatena” with stones.

Investigator: Is “matatena” the game one plays with a ball and jacks?

Participant: Yes, where I come from we have huge stones and we use them in our

gardens and yards like furniture for one to sit on and chat. Stones bring me great memories.

These textual vignettes illustrate how through participants' involvement in sandtray they were able to express themselves and engage in their own interpretations and analysis of their worlds. The creation, narration, and interpretation of sandtrays with this population were a very important component of therapeutic process for these women. The meanings and interpretations attached to the figures in their sandtrays were sources of strength and positive feelings.

The symbolism attached to the figures used in sandplay therapy is an important source of information that must be explored with the clients when appropriate. The participant's interpretations are the most important. Experts' interpretations become useful sources in addressing issues raised by the client and therefore potentially helpful in the therapeutic process. But as presented above in this study, participants' interpretations were most valuable and used in the therapeutic process. In effect, the symbolic meaning drawn from Jungian experts were kept in the awareness of the investigator. Participants were able to open up and discussed their concerns through their own interpretation of the "worlds" they created. MFW's interpretations of their sandtrays was a very important therapeutic component as they were able to narrate their world, analyzed it, and later gather some insights from their own interpretations.

Investigator's Experience

It is important to discuss the investigator's experience in this research because of the impact it could have had on the participants and thus on the investigation itself. The

investigator's culture is Latino and she lived in Mexico for several years. She therefore understood Mexican culture and was able to relate to the participant's linguistic and cultural nuances. Participants were able to bond and trust the investigator and were clearly grateful that counseling services were being offered to them. The investigator was also able to give credence to participants' idea of resiliency based on a community concept rather than individual traits. Moreover, it is questionable that an investigator with no knowledge of this community and its culture would have given credence to the concept of resiliency as community based. Such knowledge directly impacted the conclusions in this investigation.

It is also important to mention the investigator's background and bilingual skills because participants felt immediately more at ease and the investigator was able to build rapport with this population quickly. The relationship between investigator and participants more than likely impacted and contributed to the effectiveness of the therapeutic interventions and therefore the ultimate results of this investigation.

Ideas to further strengthen this investigation from the perspective of the researcher are: a) increased number of individual sessions with participants; b) greater access to population so that women who have not presented themselves to social services offices in there are would be also included; c) a different choice of resiliency instrument one that would encompass this population's definition of resiliency.

Limitations of this Investigation

Several aspects of this investigation limit the conclusions that can be drawn from this research. One significant limitation is that both assessment tools are based on the participants'

self reports: it assumes that accurate information was reported. The second limitation of this study is that the population might not be representative of all Mexican farmworker women. Most studies include farmworker women who have lived in the U. S. for less than 3 years and have had different experiences. Another limitation in the sample of this study is the population consisted entirely of women who presented themselves for services at the social service agencies contacted by the investigator. Therefore, women who have not contacted social services were not part of the study limiting generalizability of results. The researcher recognizes the uniqueness of each individual and their communities and therefore the importance of uncovering the mental health and resilience of each community. Additionally, fatigue in the completion of the instruments used in this study played a significant role in the results of total scores of the R. A. S. pre-test and post-test. Furthermore, Mexican Farmworker Women's perception of resilience included power of treatment; results might be different with a longer duration of treatment or a different type of intervention. Finally, factors not measured in this study may have contributed to the resilience of this group.

Future Research

There is so little research done on Mexican farmworker women that future research can focus on different areas of investigation. Based on the findings of this investigation short term research ideas should focus on sexual and domestic violence and family therapy issues. Education and information dissemination is imperative in order to impact this community. In addition, there is much to be uncovered in the area of appropriate assessment tools for this population. Assessment tools that address this population's education, culture, and language

proficiency issues are certainly important for further investigation.

Also important in future research is the need to capture the perspective of persons other than those of the dominant culture that have long been neglected. As Reid (1993) and Landrine (1995), have urged, investigating the frame of reference of persons belonging to minority populations must be a goal of feminist researchers. The majority of Mexican farmworker women involved in this study identified three factors that, from their own perspective, should be the focus of future research related to resilience: social support, children, and religious beliefs. Additional studies are needed to improve our understanding of the experiences and social contexts of minority groups, both Mexican and others, and to explore further the factors that lead to resilience in their lives.

Research with Mexican farmworker women is certainly wide open for possibilities and therefore opportunities that are supported by foundations and organizations should increase. The impact this population has on all of us is staggering and therefore we must give attention to their mental health issues and services.

Conclusion

The use of Sandplay therapy with Mexican farmworker women impacted their mental health status and resiliency attitudes in this investigation. Transcriptions of individual and group sessions rendered many important findings. One of the most important findings is the alarming report of history of sexual abuse and domestic violence. The mental health consequences of domestic violence cannot be overlooked. Studies have shown that women who are battered attempt suicide, have symptoms of depression, have symptoms of anxiety disorders, and

experience post-traumatic stress disorder. Another important finding is the conceptualization of resilience reported by this population. The concept of resilience as individual traits and behaviors and its assessment tools don't encompass the reports from this population's resilience and support. This population emphasizes community resilience, social networks, solidarity, and hope. Consequently, further research on resilience among Mexican farmworker women should include a conceptualization of resilience that encompasses their culture's emphasis on familism, collectivist values, and affiliation. It is also important to note that domestic violence studies and its mental health implications have not specifically identified or included Mexican migrant farmworker women, therefore specific mental health effects of domestic violence on this population are still unknown. Lastly, research on creative therapies and its impact must be encouraged to better understand the use of these therapeutic interventions with minority populations.

APPENDIX A
CONSENT FORM (ENGLISH VERSION)

July 18, 2003

Dear Participant:

My name is Ximena E. Mejía and I am a graduate student at the University of Central Florida working under the supervision of faculty member, Dr. B. Grant Hayes. You are being asked to participate in a study designed to gather information on Sandplay therapy. This research project was designed solely for research purposes and no one except the research team will have access to any of your responses. All responses will be kept confidential. Your identity will be kept confidential using a numerical coding system. With your permission, the research individual interview and group session will be audio and video taped. Only the research team will have access to the audio and videotapes. At the end of this research (by May 2004), the tapes will be erased.

Your participation in this project is voluntary. You do not have to answer any question(s) that you do not wish to answer. Please be advised that you may choose not to participate in this research, and you may withdraw from the research at any time without consequence. There are no direct benefits or compensation for participation in this study. The individual and group interviews will take approximately one hour each. There are no anticipated risks associated with participation.

If you have any questions or comments about this research, please contact Ximena E. Mejía or her faculty supervisor Dr. B. Grant Hayes, College of Education, Orlando, FL; (407) 823-0313. Questions or concerns about research participants' rights may be directed to the UCFIRB office, University of Central Florida Office of Research, Orlando Tech Center, 12443 Research Parkway, Suite 207, Orlando, FL 32825. The phone number is (407) 823-3901.

Sincerely,

Ximena E. Mejía

_____ I have read the procedure described above.

_____ I voluntarily agree to participate in the procedure and I have received a copy of this description.

Participant's signature

APPENDIX B
CONSENT FORM (SPANISH VERSION)

Septiembre, 2003

Estimado Participante:

Mi nombre es Ximena E. Mejía y yo soy una estudiante en la Universidad de Florida Central que trabajo bajo la supervisión de un miembro de la facultad, Dr. Grant B. Hayes. Estamos pidiéndole que participe en un estudio diseñado para recoger información sobre fuerzas que nos ayudan a superar con la tensión de la vida cotidiana y terapia de arena. Los datos acumulados en este proyecto están diseñados únicamente para propósitos de la investigación, y nadie tendrá acceso a esta información. Solamente el equipo de la investigación tendrá acceso a sus contestaciones. Todas las contestaciones serán guardadas confidencialmente. Su identidad también será mantenida en confidencia por medio de un sistema numérico codificado. Con su permiso, la investigación consistirá de una entrevista individual y la sesión de grupo y estas serán grabadas por medio de tecnología de audio y video. Solo el equipo de la investigación tendrá acceso a las cintas de audio y de video. Al final de esta investigación (Mayo 2004), las cintas serán borradas.

Su participación en este proyecto es voluntaria. Si usted no lo desea, usted no tiene que contestar cualquier pregunta(s) que usted no desee contestar. Por favor recuerde que si usted quiere, usted puede escoger no participar en esta investigación. También, si quiere, usted puede retirarse de la investigación durante cualquier momento de la investigación, y usted lo puede hacer sin ninguna consecuencia. No habrá ningún beneficio directo o compensación por la participación en este estudio. Las entrevistas individuales y de grupo tomarán aproximadamente una hora cada una. No se anticipan ningún riesgo asociado con participación en este estudio.

Si usted tiene cualquier pregunta o si tiene comentarios sobre esta investigación, por favor comuníquese con Ximena E. Mejía, ó con el supervisor en la facultad de Educación, el Dr. Grant B. Hayes, en University of Central Florida Orlando, FL; (407) 823 -0313. Si usted tiene preguntas sobre los derechos de participantes de la investigación por favor comuníquese a la oficina de UCFIRB, en University of Central Florida, Orlando Technology Center, 12443 Research Parkway, Suite 207, Orlando, FL 32825. El número de teléfono es (407) 823-3901.

Atentamente,
Ximena E. Mejía

_____ Yo he leído el procedimiento descrito anteriormente.

_____ Yo estoy de acuerdo en participar en el procedimiento voluntariamente y yo he recibido una copia de la descripción de esta investigación.

Firma de participante

Fecha

APPENDIX C
OUTCOME QUESTIONNAIRE OQ-45.2 (SPANISH VERSION)

OQ-45.2 (Outcome Questionnaire) Cuestionario de Resultados (OQTM-45.2)

Lambert et al., 1996

Nombre: _____

Edad: _____

ID#: _____

Sexo: M F

→ Instrucciones:

Para ayudarnos a entender como se ha estado sintiendo, b sese en los  ltimos siete d as, incluyendo el d a de hoy. Lea cuidadosamente las siguientes declaraciones y seleccione la categor a que mejor describa su situaci n. En este cuestionario el t rmino “trabajo” se refiere al empleo, la escuela, el hogar, el trabajo voluntario, etcetera. Por favor, no escriba en las areas oscuras.

		Nunca	Casi Nunca	A veces	Con Frecuencia	Casi Siempre	S D	I R	S R
1.	Me llevo bien con otros.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2.	Me canso r�pidamente.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3.	Nada me interesa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4.	Me siento presionado (estresado) en el trabajo/escuela.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5.	Me siento culpable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6.	Me siento irritado, molesto.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7.	No me siento contento con mi matrimonio / pareja.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8.	Pienso en quitarme la vida.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9.	Me siento d�bil.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	Me siento atemorizado	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

11.	Después de tomar bebidas alcohólicas necesito tomar la mañana siguiente para poder comenzar el día (Si usted no bebe, marque “nunca”).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
12.	Encuentro satisfacción en mi trabajo / escuela.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
13.	Soy una persona feliz.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
14.	Trabajo / estudio demasiado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
15.	Me siento inútil.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
16.	Me preocupan los problemas de familia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
17.	Mi vida sexual no me llena.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
18.	Me siento solo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
19.	Disputo frecuentemente.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20.	Me siento querido y necesitado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
21.	Disfruto mi tiempo libre.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
22.	Se me dificulta concentrarme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
23.	No tengo esperanza alguna en el futuro.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
24.	Estoy contento conmigo mismo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25.	Tengo pensamientos perturbantes de los que no puedo deshacer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
26.	Me molestan las personas que me critican porque tomo (o uso drogas); (Si no toma o usa drogas marque “nunca”).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
27.	Tengo malestares estomacales.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

28.	No trabajo / studio tan bien como lo hacía.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
29.	Mi corazón palpita demasiado.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
30.	Se me dificulta llevarme bien con mis amigos y conocidos.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
31.	Estoy satisfecho con mi vida.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
32.	Tengo problemas en el trabajo / escuela debido a las drogas o el alcohol. (Si no toma o usa drogas, marque “nunca”)......	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
33.	Siento que algo malo va a ocurrir..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
34.	Tengo los músculos adoloridos.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35.	Las areas espaciosas, el manejar, el estar dentro de un camion o metro, etcetera, me atemoriza.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
36.	Me siento nervioso.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
37.	Mis relaciones con mis seres queridos me satisfacen.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
38.	Siento que no me va bien en el trabajo / escuela.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
39.	Tengo demasiados desacuerdos en el trabajo / escuela.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
40.	Siento que algo anda mal con mi mente.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
41.	Se me dificulta dormir, o no me puedo quedar dormido.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
42.	Me siento triste.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

43.	Mis relaciones con otros me satisfacen.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
44.	Siento suficiente enojo en el trabajo / escuela como para hacer algo de lo que me puedo arrepentir.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
45.	Me dan Dolores de cabeza.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	TOTAL								

APPENDIX D
OUTCOME QUESTIONNAIRE (ENGLISH VERSION)

Outcome Questionnaire (OQ-45.2)

Lambert et al., 1996

		Never	Rarely	Someti mes	Frequently	Almost Always	S D	I R	S R
1	I get along well with others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2	I tire quickly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3	I feel no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4	I feel stressed at work/school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5	I blame myself for things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6	I feel irritated.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7	I feel unhappy in my marriage/significant relationship.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8	I have thoughts of endings my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9	I feel weak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10	I feel fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
11	After heavy drinking, I need a drink the next morning to get going. (If you don't drink, mark "never")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
12	I find my work/school satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
13	I am a happy person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
14	I work/study too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
15	I feel worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
16	I am concerned about family troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
17	I have an unfulfilling sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
18	I feel lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
19	I have frequent arguments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20	I feel loved and wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
21	I enjoy my spare time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
22	I have difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
23	I feel hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
24	I like myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

25	Disturbing thoughts come into my mind that I cannot get rid of.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
26	I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
27	I have an upset stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
28	I am not working/studying as well as I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
29	My heart pounds too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
30	I have trouble getting along with friends and close acquaintances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
31	I am satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
32	I have trouble at work/school because of drinking or drug use (If not applicable, mark "never")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
33	I feel that something bad is going to happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
34	I have sore muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
36	I feel nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
37	I feel my love relationships are full and complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
38	I feel that I am doing well at work/school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
39	I have too many disagreements at work/school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
40	I feel something is wrong with my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
41	I have trouble falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
42	I feel blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
43	I am satisfied with my relationships with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
44	I feel angry enough at work/school to do something I might regret	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
45	I have headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	TOTAL								

APPENDIX E
RESILIENCY ATTITUDES SCALE - R. A. S. (SPANISH VERSION)

RESILIENCY ATTITUDES SCALE (R.A.S.)

Biscoe & Harris, 1999.

(Translated by Ximena E. Mejía)

Gracias por su participation. Nosotros necesitamos saber ciertas cosas sobre usted.

¿Cuál es su género? Femenino ó Masculino

¿Cuál es su edad en años?

¿Cuál es su raza?

Blanco

Negro

Indio americano, esquimal o Aleut

Asiático o Isleño de Pacífico

Otro

¿Cuál es su etnicidad?

Hispano

No-hispanic

¿Cuál es el nivel más alto de escuela usted ha completado o el grado más alto que usted ha recibido?

Menos de Primer Grado 1

1, 2, 3, 4, 5, 7, 8 Grados

9, 10, 11, 12 Grados

Diploma de la escuela secundaria ó Equivalente (GED)

Alguna Universidad Pero Ningún Título

Título Técnico Ocupacional / Vocational

Licenciatura Bachelor Degree (BA, BS)

Título de Maestría (MA,MS,MEng,MEd,MSW)

Título Profesional (MD, DDS, DVM)

Título de Doctorado (PhD, EdD)

¿Esta usted en la escuela?

No estoy actualmente en escuela

Sí, estoy en la escuela que nivel or grado

Sí, Universidad, Estudiante,

Sí, Universidad, Escuela Técnica,

Sí, Universidad, Escuela Graduada,

¿Cuál es su ocupación actual?

¿En qué país reside usted?

Si usted vive en el EE.UU.:

¿En qué estado reside usted?

¿Cuál es su salario anual total ó en “bruto” en dólares americanos?

¿Es inglés su primer idioma? No Sí

Resiliency Attitudes Scale (RAS)

Nosotros estamos interesados en cómo usted se siente. Por favor sea tan honrado como sea posible al contestar cada una de las siguientes declaraciones. No hay respuestas correctas o incorrectas. Por favor lea cada declaración cuidadosamente y seleccione la contestación que mejor describa si usted está de acuerdo ó si usted no esta de acuerdo.

1. Normalmente yo no puedo predecir lo que otras personas harán.
2. Yo evito aceptar responsabilidad por los problemas de otras personas.
3. Hay buenas razones para que otros piensen mal de mí.
4. Yo persivo ciertos problemas en ciertos signos que tienen ciertas personas
5. No es necesario el tratar de reflexionar en el por qué de las cosas que pasan.
6. A menudo yo me encuentro tomando responsabilidad por los problemas de otras personas.
7. Yo estoy preparado para hacerme preguntas duras y contestarlas honestamente.
8. Yo tengo dificultad en determinar que clase de persona es una persona a quien acabo de conocer.
9. Yo puedo sanar heridas de mi pasado que podrían impedirme el permitir a personas que se acercan ha mí.
10. A mi me interesa saber el por qué las personas actúan la manera que lo hacen.
11. A menudo frecuento con personas las cuales yo sé que son personas malas para mí.
12. Puedo verme aparte de ciertos miembros familiares con problemas, y todavía me veo que soy una buena persona.
13. Si usted ama ha alguien, usted debe intentar hacer todo lo que la persona quiera, aún cuando le parezca irrazonable.
14. Yo no puedo evitar ha actuar como un niño alrededor de mis padres.
15. Yo puedo reconocer cuando yo estoy en una relación mala y la acabo inmediatamente.
16. Yo puedo estar calmada alrededor de las personas con problemas porque yo entiendo por qué ellos actúan de la manera que ellos lo hacen.
17. Yo comprendo que yo no puedo cambiar a otras personas; ellos tienen que cambiar por ellos mismos.
18. Es duro para mí quedarme calmada cuando alguien a quien yo amo está siendo irrazonable.
19. Si yo amo a alguien, yo puedo aguantar que esa persona me hiera.
20. Me encuentro a menudo alrededor de las personas que no son saludables.
21. Hay ciertas personas con las cuales you sé que realmente puedo contar.
22. Yo estoy bueno en juzgar a las personas.
23. Yo intento saber por qué una relación en la que yo estuve envuelta no fue saludable y evito repetirlo.
24. Yo soy bueno para empezar relaciones con otras personas.
25. Yo no puedo hacer nada sobre como otras personas piensan de mí.
26. Es duro para mí creer que yo alguna vez encontraré una relación buena.
27. Yo soy tímido alrededor de las personas que yo no conozco.
28. Yo realmente no puedo decir si una relación va a ser buena hasta que yo me envuelva en esa relación.

29. Yo soy bueno para seguir en relaciones.
30. Yo puedo amar a otros y sentirme amado por ellos.
31. Está más allá de mí cómo más más del trabajo de las cosas.
32. A menudo yo siento que puedo resolver mis problemas.
33. Yo puedo aprender del pasado y puedo usar esa información para hacer del futuro mejor.
34. Yo tengo aficiones y otras actividades que me entretienen y las cuales yo tomo en serio.
35. A menudo me siento muy frustrado al tratar con problemas y no sé qué hacer.
36. Yo tengo éxito en cuidar de mis necesidades físicas y emocionales.
37. No me gusta averiguar cómo el trabajo de las cosas.
38. Hay pocas cosas en las cuales you soy excitoso.
39. Yo hago lo suficiente para sobrevivir, pero no quiero hacer mucho más.
40. Yo disfruto cuando estoy involucrado en actividades constructivas.
41. A veces yo me olvido de mis problemas cuando yo estoy haciendo actividades creativas.
42. Yo no pienso que yo soy creativo.
43. Yo soy bueno para encontrar nuevas maneras de mirar a las cosas.
44. Hay maneras creativas en las cuales yo expreso mis sentimientos de arte, baile, música o escribiendo.
45. Los sentimientos positivos que yo recibo de crear ayuda recuperan el dolor de mi pasado.
46. Normalmente mi imaginación no ayuda resolver problemas.
47. Es difícil para mí el ver humor en una situación mala.
48. Uno tiene que tomar la vida muy en serio para sobrevivir.
49. Uso el humor para reducir tensión entre mí y otros.
50. La mayoría de los problemas tiene sólo una solución.
51. Encuentro fácil el escoger entre lo bueno y lo malo.
52. La vida es muy difícil y uno tiene que hacer lo que uno necesita para sobrevivir.
53. Yo no puedo evitar el repetir los errores que mis padres cometieron.
54. Me gusta ayudar a otras personas.
55. No hay ninguna manera que yo podría hacer a una diferencia en las vidas de otras personas.
56. Yo no hago siempre lo que yo sé es lo correcto.

57. Yo me confronto a las personas cuando yo las veo que son deshonestas ó crueles.
58. Yo tomo riesgos cuando yo pienso que tengo la razón.
59. A veces me siento como si no tuviera propósito en la vida.
60. Yo casi siempre defiendo a los desvalidos.
61. Me gusta ayudar otros aun cuando ellos no quieran ayudarse a ellos mismos
62. Yo estoy envuelto en cosas que harán una gran diferencia para las vidas de otras personas.
63. No importa lo que pase, si yo sigo intentando que yo lo lograré.
64. Hay cosas que yo puedo hacer para hacer mi vida mejor.
65. A veces es duro, pero yo no permito que las cosas difíciles me controlen.
66. Aún cuando las cosas malas pasan, yo puedo enfrentarme a ellas.
67. No es la mano que a usted se le reparte, es cómo usted juega la mano que le toca.
68. No importa cuanto yo lo intento, yo no puedo hacer las cosas bien.
69. Yo quiero utilizar cualquier un modelo que me de resultados.
70. Yo soy bueno para hacer una Buena situación de una situación mala.
71. Cuando la vida me da limones, yo hago limonada.

72. El fracaso es algo del que usted aprende en lugar de sentirse culpable.

APPENDIX F
RESILIENCY ATTITUDES SCALE R. A. S. (ENGLISH VERSION)

RESILIENCY ATTITUDES SCALE (R.A.S.)

Biscoe & Harris, 1999

<http://www.dataguru.org/ras/take>

Resiliency Attitudes Scale (R. A. S.)

Demographics

First, we need to know a few things about you.

What is your gender?

What is your age in years?

What is your race?

What is your ethnicity?

What is the highest level of school you have completed or the highest degree you have received?

Are you current in school?

What is your occupation?

Is English your first language?

We are interested in how you view yourself. Please be as honest as possible when rating each of the statements below. There are no right or wrong answers. Please read each statement carefully and select the response that best describes how strongly you agree or disagree with that statement.

1. I usually can't predict what other people will do.
2. I avoid accepting responsibility for other people's problems.
3. When other think badly of me, there's probably a good reason for it.
4. I try to notice signals from other people that spell trouble.
5. It doesn't do any good to try and figure out why things happen.
6. Often I find myself taking responsibility for other people's problems.
7. I am willing to ask myself tough questions and answer them honestly.
8. I have a hard time telling what someone new is like until I get to know the person well.
9. I can fix hurts from my past that could keep me from letting people get close to me.
10. I try to figure out why people act the way they do.
11. I will often stay with someone even though I know that person is bad for me.
12. I am able to step back from troubled family members and see myself as OK.
13. If you care about someone, you should try to do what the person wants, even if it seems unreasonable.
14. I can't help acting like a child around my parents.
15. I am able to recognize when I'm in a bad relationship and end it.
16. I can stay calm around troubled people because I understand why they act the way they do.

17. I realize that I can't change other people; they have to change for themselves.
18. It's hard for me to stay calm when someone I care about is being unreasonable.
19. If I love someone, I can put up with that person hurting me.
20. I often find myself around people who aren't well adjusted.
21. There are few people who I can really count on.
22. I am good at sizing up people.
23. I try to figure out why a relationship is not healthy and avoid repeating it.
24. I am good at starting relationships with other people.
25. I can't do anything about whether other people like me or not.
26. It's hard for me to believe that I'll ever find a good relationship.
27. I'm shy around people I don't know.
28. I can't really tell if a relationship is going to be good until I try it.
29. I am good at keeping relationships going.
30. I am able to love others and be loved by them.
31. It's beyond me how most things work.
32. I often talk myself through a problem.
33. I can learn from the past and use that information to make the future better.
34. I have hobbies and other activities I take seriously/
35. I often get really frustrated when dealing with problems and can't figure out what to do.
36. I am successful at taking care of my physical and emotional needs.
37. I don't like to find out how things work.
38. There are few things that I am good at doing.
39. I do enough to get by, but not much more.
40. I enjoy getting involved in constructive activities.
41. Sometimes I forget my problems when I'm pursuing creative activities.
42. I don't think that I'm creative.
43. I'm good at finding new ways to look at things.
44. One way I express my feelings is through my art work, dance, music or writing.
45. The positive feelings I get from creating help make up for the pain of my past.
46. Usually my imagination doesn't help to solve problems.
47. It's hard for me to see the humor in a bad situation.
48. One has to take life very seriously to get by.
49. I am good at using humor to reduce tension between myself and others.
50. Most problems have only one solution.
51. I find it easy to choose between right and wrong.
52. It's a dog eat dog world where one has to do what it takes to get by.
53. I can't help repeating the mistakes that my parents made.
54. I like to help other people.
55. There's no way I could make a difference in other people's lives.
56. I don't always do what I know is right.
57. I stand up to people when I see them being dishonest, petty or cruel.
58. I am willing to take risks for the sake of doing what I think is right.
59. Sometimes I feel like I'm just drifting along with no purpose in life.
60. I almost always stand up for underdogs.
61. I like to help others even if they are not willing to help themselves.

62. I am involved in things that will make people's lives better.
63. No matter what happens, if I keep trying I'll get through it.
64. There are things that I can do to make my life better.
65. Sometimes it's hard, but I don't let things keep me down.
66. Even if bad things happen, I can handle with them.
67. It's not the hand you are dealt, its' how you play it.
68. No matter how hard I try, I can't make things right.
69. I am willing to go with any approach that will work.
70. I'm good at making the most of a bad situation.
71. When life gives me lemons, I make lemonade.
72. Failure is something you learn from rather than feel guilty about.

APPENDIX G
PSYCHOSOCIAL HISTORY

PSYCHOSOCIAL HISTORY

Name _____ Age _____

Address _____

Birthdate _____ Telephone _____

Marital Status Single Married Divorced Widowed Separated

Race White Black Hispanic Asian Other _____

Ethnicity / Country (where are you from?) _____

If Immigrant in this country, how long have you been here? _____

Presenting Problems Checklist

Relationship Issues

Marital	Parent/Child	Child/Adolescent	Family System
Arguing/conflict	Communication	ADHD	Blended family
Children	Defiant behavior in child	Alcohol/drug abuse	Boundary issues
Communication	Discipline	Enuresis/encompresis	Death
Divorce	Emotional abuse	Learning disabilities	Disengagement
Ex-spouse	Peer relationship	Legal charges	Economic
In-laws	Physical abuse	Lying	Enmeshment
Infidelity	Running away	School	flexibility
Money	Sexual abuse	Sexual identity	Incest
Physical abuse	Step parent	Stealing	Life-cycle transition
Separation		Step sibling	Mental illness
Sexual difficulties		Suicidal risk	Physical illness
Step parenting roles		Trauma	Power struggles
			Rigidity
			Role conflict
			Triangles

Personal Issues

Adjustment problem	Financial problems	Phobias	Sexual abuse
Anxiety/panic attacks	Grief or loss	Physical abuse	Sexual assault

Career decisions	Impulse control	Psychological problems	Sexual dysfunction
Crying spells	Legal	Psychotic features	Sexual orientation
Death	Medical issues	PTSD	Stress
Depression	Mood swings	Racial/cultural concerns	Suicide ideation
Developmental issues	Obsession/compulsion	Relationship violence`	Weight management
Eating disorder	Personality disorder	Self-esteem	other

PSYCHO-SOCIAL HISTORY

1. Family History

Parents (Married; Divorced; Step-parents; ages; Living/deceased; occupation; describe past relationship and current relationship).

Siblings (Age; describe past relationship and current relationship).

2. Educational / Occupational History

Education: (Highest grade achieved; school performance/ special classes/ special needs).

Occupational (Job status, kinds of jobs, length of employment, vocational interests).

3. Medical History

Previous medical problems (describe physical injuries, accidents, major illnesses).

Current health (Describe any current medical problems; prescription drugs).

Previous Psychiatric Treatment (Describe outpatient and hospitalization treatments).

Substance Usage (Have you or do you drink alcohol? How often? How much? Have you or

do you use any type of drugs? How often? How much?

4. Relationship History

Current Status (Years married or with significant other; numbers of children; problems stressor, enjoyment).

Client's description of current relationship with spouse of significant other.

5. Religious / Spiritual Issues

Are religious or spiritual issues important in your life?
Are you committed to your spiritual affiliation and actively involved in it?

6. Suicide Assessment

Suicide Assessment (specific plan, lethality, availability, support network, contract status).

Diagnostic Impression

Diagnosis:

- Axis I
- Axis II
- Axis III
- Axis IV
- Axis V

Treatment Plan

Primary Problem

Goals:

Therapeutic Interventions:

Secondary problem

Goals:

Therapeutic Interventions:

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