Clanship andK'È: The Relatedness of Clinicians and Patients in a Navajo Counseling Center

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ARTICLE

Clanship and *K'é*: The Relatedness of Clinicians and Patients in a Navajo Counseling Center

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Abstract I examine the significance of clanship ties among mental health clinicians and patients in a counseling center on the Navajo Nation. Navajo clans are matrilineal, exogamous, and geographically dispersed social units. Clan relatives are expected to observe the rules of conduct embodied in the behavioral code of *k'é*. This code structures social interaction among clan relatives, obliging each party to employ intimate, age-appropriate kin designations in personal address and to act towards kinfolk compassionately and respectfully. I explore the ethical dilemmas that can arise when clinicians and Navajo patients invoke clan relatedness to shape the contours of their therapeutic relationships.

Key words clan • ethics • mental health • Navajo • practitioner–patient interaction

When the Navajos named themselves they called themselves The People [Diné] – they being The People on earth.[1] Outsiders gave them another name, Navajo. They are the ones who consider themselves to be made up of different clans. That is the way they determine their relationship. Whenever two Navajos meet, they immediately ask, 'What clan are you?' and then, 'What's your father's clan?' They find out whether or not they are relatives . . . (Sandoval, 1954: 20)

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> *K'é* is something that you cannot pinpoint and say this is *k'é* and all of that. *K'é* is kind of like being a Navajo. . . It's who you are as a person. It's always a part of you. It's how you interact with another person; how you respect that person; how you communicate with that person. It's being polite, being respectful, and being cordial. It's just a total thing that goes with it. And that's always there. I'm very very conscious of that. . .
>
> (Irene, Navajo psychologist, interview)

Introduction

Hózhóógo Naasháa Doo Counseling Services (HCS), a U.S. Indian Health Service (IHS) mental health facility on the Navajo Nation, is a unique social space in which Navajo and non-Navajo clinicians of differing professional backgrounds strive to craft and deliver high-quality, culturally relevant services.[2] In this article, I examine the clinical value of kinship ties that exist among the HCS providers and their Navajo patients. These ties are not biological in origin, but instead attain their significance through an elaborate system of social organization that is predicated upon clan relations. Clans are classically defined as descent groups comprised of persons who lay claim to common ancestors, although their forebears' actual genealogical linkages have been obscured with the passing of generations (Stone, 1997).[3] Navajo clans are matrilineal and exogamous, with sexual relations and marriage prohibited among clan members (Aberle, 1961).

The mother–child relationship is at the core of the Navajo clan system. One's birth automatically confers membership in the mother's clan. This clan defines the individual's primary descent identity. While an individual is *born in* or *of* the mother's clan, the Navajo concept of *born for* acknowledges one's descent connections to the father's matrilineal clan.[4] Most Navajos also acknowledge connections to their maternal grandfathers' and paternal grandfathers' matrilineal clans.[5] Persons who share membership in one or more of these named clans are regarded as relatives. Relatives are expected to observe the rules of social conduct that are embodied in the behavioral code of *k'é*. This code structures interactions among relatives, obliging each party to employ intimate, age-appropriate kin designations in personal address (e.g. sister, mother, grandmother) and to engage one another in a cooperative, compassionate, and respectful manner.

The present article was prompted by the uncertainties that surround clan relatedness between providers and patients in the clinic, voiced largely by the Navajo clinicians at HCS. Although they would affirm the cultural relevance of clan relatedness, professing that it smoothes processes of rapport building, the Navajo clinicians repeatedly expressed concern that the formation of kin-based solidarities might interfere with therapy.

My objective is to shed light on the clinical dilemmas that can arise when

providers disclose their clan affiliations to new patients and how this can shape the contours of therapeutic relationships. I also seek to address the practical reasons why providers would ultimately choose to operationalize expressions of Navajo kinship in casework. In contemplating the multifaceted role of the clan introduction in clinic work, I focus on one strategy employed at HCS to set patients at ease and to help providers obtain what is ostensibly elusive and sensitive information from patients. This information can be crucially relevant to the identification and analysis of mental health conditions presented by patients.

Ethical Issues at *Hózhóógo Naasháa Doo Counseling Services*

The norms of professional conduct in biomedical settings construct clinical relationships as distinct from all other social relationships (Roberts, Battaglia, & Epstein, 1999; Roberts, Battaglia, Smithpeter, & Epstein, 1999). In the cultural parlance of Euro-American psychoanalysis, therapeutic boundaries 'frame' the relationship between clinician and patient. The 'therapeutic frame' imparts the behavioral ground rules by which the clinician and the patient presumably agree to abide throughout the therapeutic process. Standard recommendations that assist clinicians in configuring this frame and sustaining its integrity include: guarding against previous, current, or future personal involvement with patients; abstaining from excessive personal revelation; maintaining relative neutrality; fostering patients' psychological independence or autonomy; and protecting patients' confidentiality (Epstein, 1994). The bounded frame is a cultural ideal espoused in most mental health disciplines, and is modeled on notions of the patient as a contained, self-determining individual.

Socio-centric conceptualizations of Navajo identity do not mesh neatly with the therapeutic assumptions and ethical precepts that underpin Euro-American mental health practice. Such conceptualizations also are contrary to biomedical constructions of the patient as an individual entity. In the Navajo ethnomedical system, in which the boundaries of the therapeutic frame are flexible, social ties between healers and patients are common.[6] Although such ties are generally discouraged in the mental health professions, Navajo clinicians at HCS regularly encounter patients with whom they share clan connections. Likewise, Navajo sacred healers often are the close friends or relatives of their identified patients. An identified patient's treatment may require significant involvement from kin. They, in turn, may be transformed into secondary patients responsible for ensuring that the sacred healer's post-treatment directives are carried out. Running counter to the mental health clinician's emphasis on neutrality, such prescriptive directives may be geared principally towards these

secondary patients, requiring them to alter problematic behavioral and affective relationships with one another and with the identified patient (Topper & Curtis, 1987).

In this article, I consider the ethically complex nature of overlapping social roles, clarifying how these roles can enrich clinical relationships at HCS, but also pointing to their potentially problematic dimensions. As I make clear, clanship issues also bear influence in the work of non-Navajo clinicians, some of whom are themselves treated by Navajo coworkers as though they were close kin.

An introduction to the Navajo clan system and the behavioral code of *k'é* is followed by descriptions of the research setting and the project participants. I then examine how HCS staff members construct the clinical value of *k'é* and clan, highlighting the diagnostic implications of kin taboo breaches. To underscore the broader implications of clan in clinic work, the discussion turns to intrastaff clan linkages. A final section summarizes pertinent ethical issues that emanate from the existence of dual relationships between clinicians and their patients.

Conceptualizing Clan and Clan Identification in Social Interaction

The clan system is not a nostalgic throwback to a bygone era in Navajo history. Sixty clans thrive among the Navajo today, the first four of which were created by the *Diyin Dine'é* or the Holy People (Aronilth, 1991).[7] The original clans include *Tó'áhání* (Near the Water), *Kin yaa'ánii* (Towering House), *Tó dích'íi'nii* (Bitter Water), and *Hashtł 'ishnii* (Mud). Clan designations bring to mind the varied topographic features found in and around *Diné bikéyah*, the homeland of the Navajo, which spans into the states of Arizona, New Mexico, and Utah. When Navajos chance upon Navajos with whom they are unfamiliar, they may introduce themselves by their clans, and thus associate themselves in dense filial networks that stretch across the Navajo Nation and beyond its borders.

Clan identification, which entails the verbal disclosure of one's membership in these broadly defined kin groups, is common in day-to-day social interaction in Navajo society. In the clinic, it can constitute a vitally important part of practitioner–patient relationships. As explained by one Navajo clinician, 'Even with clients whose cases are closed, the clan connection continues. But they are no longer my clients. They are my relatives.' This clinician added:

> Some people don't think clan is important, but it is. For me, clan helps establish rapport and instead of clients opening up to you only after having a number of sessions, we'll talk about clan in the first session. And when we see each other again, the clients feel more comfortable.

In seeming contrast, many Navajo patients contest the practice of querying them about their clans in clinical settings, and demand that references to clan not be included in their permanent medical records. This information surprised one Anglo clinician, who previously assumed that Navajo patients were appreciative when their providers appealed to clan in the course of therapeutic encounters.[8]

HCS clinicians are hesitant either to oversimplify or to overemphasize the importance of clans in mental health work. Even so, the clinicians – Navajo and non-Navajo alike – work under the auspices of a culture-specific worldview that is ubiquitously known as 'the Navajo Way.' A crucial component of this worldview is *k'é*, the behavioral code of the clan system. Benally (1992), an instructor of Navajo history and philosophy, associates *k'é* with the capacity to love, respect, care, and hold other persons in high esteem.

The HCS clinicians theorize and talk about *k'é* in a reasonably broad context.[9] They tend to use the terms 'clan' and '*k'é*' interchangeably, invoking the latter as both noun and verb, and defining it as a system of moral and social order. Although *k'é* and clan-based alliances may be seen as important in mental health practice, challenges emerge as clinicians allow kinship affiliations to shape the various facets of their work lives. For instance, clan ties to coworkers can present deterrents for Navajo staff members who are thinking of assuming official leadership roles in the clinic. By revealing how such predicaments come to the fore in the clinic, I am not arguing that *k'é* and clan ties pose disadvantages to the carrying out of one's job responsibilities. Quite the opposite, I seek to highlight how *k'é* can enhance the ability of clinicians to work well with patients and peers.

The Research Setting: Hózhóógo Naasháa Doo Counseling Services

HCS offers mental health and medical social services, specializing in crisis intervention as well as individual, group, and family therapy. HCS is larger than most counseling clinics on the reservation, employing twenty or so people. The staff consist of psychiatrists, psychologists, social workers, mental health specialists, case managers, and clerical personnel.[10] Six clinicians are classified locally as *bilagáana*, or 'Anglo,' although their ethnic backgrounds are quite dissimilar. Most staff members at HCS are of Navajo descent and can speak the Navajo language fluently. Clinicians lacking proficiency in Navajo appeal to their coworkers, including the clerks, for help. English-speaking psychiatrists and Navajo-speaking clinicians often share responsibility for select cases: the former focus on medication management and the latter on talk therapy.

Patients come to HCS for many reasons. Some patients seek services because they feel that their problems have become too tough to deal with alone. In the language of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 1994), the problems affecting this segment of the patient population cluster around mood disorders, adjustment disorders, anxiety disorders, partner–relational problems, and parent–child relational problems. It is not uncommon for family members, including clan kin, to refer troubled loved ones to HCS, but only a fraction of referrals come from this source. Judges and attorneys from the tribal court refer males and females of all ages who are grappling with criminal issues related to substance use or domestic violence as well as child abuse and neglect. Women's shelters, Tribal Social Services, Behavioral Health (the tribal substance abuse program), Vocational Rehabilitation, and local schools also make referrals.

The clinic's walk-in system allows most patients to receive services on demand, but pre-arranged follow-up appointments help ensure consistency in care. However, many patients fail to keep their appointments because they lack transportation to and from HCS. Other patients are reluctant to engage in psychotherapy because it requires long-term commitment, whereas healing in the Navajo ethnomedical system usually does not. For instance, after undergoing a ceremony or a series of ceremonies that are intended to remove the cause of an illness, an HCS patient may no longer feel the need to continue psychotherapy, although the clinician might argue otherwise. To strengthen the therapeutic relationship and to encourage consistency in mental health care, some clinicians try forging alliances with patients that are based upon the time-honored clanship system of the Navajo people.

Clan and *K'é* in Clinical Practice

The first interaction involving the clinician and the patient is called an 'intake.' During the intake the clinician 'screens' the patient to determine the scope of the mental health problem. A few clinicians, Navajo and Anglo alike, readily use clan introductions during the intake. Partially because of their socialization into mental health disciplines, other clinicians are less inclined to do so, preferring instead to maintain judiciously a level of professional decorum and privacy.

In an impromptu staff discussion regarding *k'é*, Irene, who is one of a handful of Navajo psychologists possessing doctorates, expressed ambivalence over the clinical appropriateness of disclosing her clans to patients:

> I'm not sure about whether I should say, 'This is my clan and this is who I'm related to.' I don't know if that is going to interfere with the therapy. But if

> they do ask, sometimes I do say, 'I'm from this clan.' But if they don't ask, sometimes I just leave it. I don't really know how to handle that . . . I feel that I may get into trouble if they are of my own clan, and ask 'Oh, do you know so and so?' 'Where are you from?' 'I have a relative over there.' That's where I'm concerned and I really don't want to go into that. It becomes a kind of personal type thing. (Irene – staff discussion)

For Irene, the issue of positionality is paramount. Should she compromise the safe conventional structure of the therapeutic relationship, in which she is clearly recognized as the clinician and her interlocutor as the patient, or allow affective kinship and her social identity as a Navajo to serve as the cultural fabric binding this relationship? Emily, a psychiatrist of Navajo and Anglo heritage, empathized strongly with Irene's dilemma. Educated by Navajo elders to observe *k'é* during interactions with clan kin, Emily revealed to coworkers that she too has wrestled over the years with conflicts stemming from her professional role as a biomedical practitioner and her cultural and spiritual identification as a Navajo woman:

> In the western world of medicine, you're trained to have all these boundaries around you with your patients, and to kind of be in a bubble in a way. So it really sets you apart. But when you come back into a world like this where it is very important to know what to say – 'how do I relate to you?' – and that type of thing . . . I think that you have to do what's comfortable for you and then see how that plays out into your relationship down the road. Did that help? Did getting that information seem to help establishing rapport or something like that? Sometimes you feel that you're giving up too much of that training you have, but yet you know that you need to in order to work with somebody. (Emily – staff discussion)

Nodding their heads in agreement, several Navajo clinicians made similar disclosures, intimating that they too are willing to collapse the institutionalized power differentials that set apart the therapist from the patient.

Sarah, a Navajo social worker, has found that acknowledgements of clan relatedness can actually broaden the scope of therapeutic encounters:

> Let's say a woman is my sister by clan, I may be more apt to give her more advice on her child possibly, but you know . . . I wouldn't be violating anything in the Navajo Way but I might be in the White Man's Way. (Sarah – interview)

In this example, if Sarah is to identify herself as *shádí* (senior sister) and the patient as *shideezhí* (junior sister), then in keeping with *k'é*, the patient might feel duty-bound to abide by Sarah's advice. This can serve to undermine the patient's psychological independence (a desired state of cognizance in psychotherapy), dissuading the patient from deliberating

upon what she must do to either get well or back on track. Conversely, the social dynamics of *k'é* relations might increase the patient's interest in receiving services from Sarah or another clan relative.

The exchange of kin terms, like *shádí* and *shideezhí*, may result in the creation of affective bonds that necessitate the enactment of specific behavioral codes based upon the interlocutor's age and gender. Serving to define the relationship's nature, the decision to use certain kin terms will affect future interactions involving the speaker and this interlocutor. Thus, if two parties of the same generation but of different genders discover they are born of the same clan, they may choose to relate to one another as siblings. Relations among siblings are subject to several social conventions. A Navajo clinician observed, 'If you were taught the taboos at a young age, you're aware of the unspoken rule that you can't get intimate with your clan siblings.' However, aside from the restrictions placed on the levels of familiarly that are permitted in their physical encounters, siblings have other precepts to which they must ideally abide. For instance, the junior sibling is to obey the senior sibling; arguments between the two are frowned upon and greatly discouraged (Benally, 1992).

By obliging mutual displays of respect in social interactions, several Navajo clinicians explained that *k'é* and invocations of relatedness help foster positive self-esteem among those patients who seem to lack a sense of belonging. Clarifying that *k'é* actually encompasses both kinship and non-kinship forms of solidarity, Priscilla, a Navajo social worker, elaborated on 'interdependence' as constitutive of *k'é*, highlighting the concept's organic and non-provincial nature:

> *K'é* is many things at different levels. I was taught that it meant knowing yourself, your clans, your tribe, your affiliated clans. And not only that but intertribal relationships, like with the Apaches and the Athabascans[11] . . . It also means your relationship with the animal world. Even with creation as a whole. Like even when you pray . . . A prayer like some Plains Indians, they'll say 'grandfather.' Here we'll say . . . like 'earth,' 'my mother,' and *shitah*, 'Father Sky.' So it's not just on earth dealing with physical forms but also your connectedness with the universe. (Priscilla – interview)

In a humorous manner, Lauren, a Navajo social worker, voiced a similar understanding of *k'é*, forcefully conveying that the implications of affective solidarity are far-reaching:

> When I say *k'é*, it brings up my own immediate family, my sister, my mom, and my extended relatives. . . Also for me it has a kind of universal meaning, you know, with Mother Earth and with the different deities [the *Diyin Dine'é*] and with the different types of life forms here on the earth. And also in the heavens too . . . Solar systems and stuff like that. My kids are funny. They would say things, 'Mom. Mom. What would you do if you saw a flying

> saucer or people from outer space?' I would say, 'All my relations!' [Laughter.] Because when you say 'All my relations,' you're including them. They're your relatives too. (Lauren – interview)

Robert, an Anglo psychiatrist, had married into a Navajo family. Called 'in-law' by his Navajo coworkers, he viewed *k'é* as a way to launch positive relationships:

> Navajos are very spread out and a lot of times when you are spread out, you come across a person you never met before. *K'é* is a way of establishing connections with people. It's an easy way of saying we're related so we'll support each other. We are related so I have to show you respect . . . It engenders many possibilities for you to define a relationship. I think that defining a relationship is an important process, *k'é* gives you a starting place, not a negative one. So with somebody you don't know, it's easy to become an enemy, but if you have a relationship that is defined in some kind of way, then you get over that hurdle. (Robert – interview)

The tenets of *k'é* solidarity include love, compassion, cooperation, friendliness and peacefulness (Witherspoon, 1977). The stress on harmony and order that is implicit in the Navajo concept of *hózhó* also is implicit in *k'é*.

As described in Witherspoon (1983, p. 573), *hózhó* refers to 'beauty, harmony, good, happiness, and everything that is positive.'[12] There can be no order or harmony among unrelated entities, but by emphasizing obligations of assistance and generosity, the behavioral principle of *k'é* contributes to the maintenance of *hózhó*. As one Navajo clinician declared, 'Being aware that you have immediate and extended family is important. You may think you're alone, especially when you're off-reservation. But when you meet a clan relative, you become happy. *Hózhó* is restored.' The enactment of *k'é* ideally enables Navajos to relate themselves to other persons, including those with whom they do not share bloodline connections.[13] This, in turn, makes it possible for Navajos to participate in 'the vast system of interdependence that characterizes the social harmony and order of their world' (Witherspoon, 1977, p. 89).

Reconciling the centrality of interdependence in Navajo social process with the demands of mental health practice is not easy. In some situations, the clinician may be hesitant to broach sensitive subjects with the patient. An experienced Navajo social worker, for example, revealed that it is intensely difficult for her to talk about sexuality issues with 'grandpas,' but she has no qualms discussing such issues with patients classified as 'grandsons.'

Concerns also exist that the machinations of *k'é* relatedness could engender situations in which the patient is poised to manipulate the clinician. Emphasizing the 'responsibilities' that emanate from one's clan

links, Gloria, a Navajo counselor from a tribal organization, contemplated the pros and cons of relatedness between professional providers and their clients:

> When you've established that someone is your clan relative, you've added another person to your family. So if I was to meet that person somewhere else, let's say outside the office, and they needed help, they wouldn't hesitate to ask me and I wouldn't hesitate to help them. I've pitched in, attending weddings and ceremonies for former clients who are related to me by clan. Some providers might not want to do it. They might not want to take on the extra responsibility . . . In the old days, it was a mandate that if people would seek you out that you would help them. The help needn't be financial. It could be listening. However, in this fast-paced day and age, people have little time to do those things. That's why some people don't want to divulge their clans in the counselor–client relationship. The other reason is that some clients will take advantage of the clan relationship. They'll ask you for money or things. Some of them play it to the extreme and they become nuisances. (Gloria – interview)

Practitioners of psychiatry transfigured these same concerns into ethical issues surrounding the mental health clinician's neutrality. The principle of neutrality requires clinicians to refrain from talking too much about themselves in the presence of patients. They also should not meddle in the personal lives of patients, and should steer clear of extratherapeutic social contact (Epstein, 1994). Gerald, a psychoanalyst of Euro-American heritage, suggested that the act of revealing one's clans to patients detracts from the therapeutic process, particularly when working among patients diagnosed with personality disorders:

> The therapist's disclosure of their clan relationships . . . is never a neutral thing to the patient and has a lot of potential to be used in an anti-therapeutic way, especially by personality disordered patients. These patients, even more than others, are prone to exploit whatever they know about a therapist in order to avoid the painful growth experience that they can potentially have in a properly 'bounded' therapeutic relationship.[14] (Gerald – written correspondence)

Recognition of the clan relationship might reassure such patients that their therapists are compassionate, caring, and respectful of their needs. However, echoing Gloria's remarks about the misuse of kin ties, Gerald alleged that some patients perceive themselves to be privy to entitlements, believing that the usual clinical norms of practice do not apply to them. Anticipating rejection or abandonment – an expectation that can lead to manifestations of volatile behavior – they might burden their therapists with heavy emotional demands, cajoling these clinicians to transgress the therapeutic frame in order to demonstrate sincere concern for their

well-being. Encompassing implicit social obligations, clan ties offer them additional leverage with which to place demands on their therapists and to have these demands filled. Taking into account this possibility, Gerald explained, 'I think a strong case could be made for the therapist to explain to the patient as directly and clearly as possible why the therapist's stating of his or her clan should best wait for the successful completion of the therapy.'

Gerald's questioning of the appropriateness of clan disclosures in mental health practice helps underscore the dilemmas of grafting Euro-American psychiatric concepts, such as neutrality, into clinical interactions involving Navajo patients. For example, when caring for older Navajos, the avoidance of clanship protocols might actually impair the development of trusting alliances. With elder patients, the exchange of clan designations and kinship terms, even if the two parties are not formally related through clan, is generally perceived by the Navajo clinicians as a sign of mutual respect that fosters cooperation:

> If they're my grandfather, and I want to encourage him to get into a nursing home, I might say s*hicheii* [maternal grandfather] if he is of the *Tó'áhání* clan [Near the Water]. But sometimes I'll say that to any elderly man, regardless of his clan I'd address him as *shicheii*. I find myself doing that with elderly women too, regardless of their clan I might say *shimá* [mother] or *shimásání* [maternal grandmother]. (Priscilla – interview)

> If I get a patient that's really kind of stubborn or doesn't want to say anything, or they're traditional, I address that person if he is a man and older than me as *shizhé'é* [father], then that kind of opens the door for you. Some of these patients that have a hard time expressing how they feel, I address them that way and they seem to open up. (Elsie – interview)

Since the importance of *k'é* and clan had been inculcated in many Navajo clinicians during their own childhoods, that they turn to kinship solidarities in interactions with Navajo patients is not surprising. *K'é* is pivotal to their most basic understandings of the Navajo Way, and is fundamental to the reproduction and continuing enactment of Navajo ethnicity in the clinic milieu. By allowing *k'é* to enter into clinical transactions, Navajo clinicians not only strengthen relations with patients, but they actively convey that it is perfectly acceptable to identify culturally as 'Navajo' within the biomedical setting.

Some Navajo clinicians also believe that acknowledgements of clan ties are diagnostically useful, aiding to uncover vital information relating to the patient's cultural identity, preference for sacred or secular healing, upbringing and family relationships. One Navajo clinician explained:

> I try to use clan introductions during intakes. That way I'll know if my

> patients want to carry on with the traditional healing. I'll also know whether they know something about their culture. Some people who come in, they don't know their clans. If I ask them if they're interested in traditional healing, they'll say no. They stay away from it. (Navajo clinician – interview)

Although she is not Navajo, Charlene, a psychologist, has enough understanding of the Navajo language to make use of clan introductions.[15] She finds that the clan introduction is constructive in her work with youngsters and their families; it functions as a vehicle to obtain culturally relevant information:

> When I ask children what their clans are, that says a lot to me about how these kids are raised and about whether [families] are traditional or not. If they're traditional, I would expect [them] to be teaching their kids about *k'é* and how to introduce themselves by clans. (Charlene – interview)

As recognized by Charlene, *k'é* and the clan system can have an uneven or insignificant influence in the social lives of Navajo patients.[16] For some patients, the pertinence of *k'é* is restricted mainly to one's immediate consanguine relations. (To paraphrase a Navajo community member: 'I only relate to people in my immediate and extended families, like my cousins, as clan kin. I tend not to relate to strangers or people I don't know well in that manner.') For other patients, many of whom must contend daily with intense family discord, *k'é*, with its emphasis on compassion and respect, is nothing more than a hollow ideal of the Navajo Way. While asking about clan can generate a reply that might help the clinician better assess the patient's upbringing and cultural identity, the response might not contribute much to rapport building.

Some Anglo clinicians took it upon themselves to incorporate *k'é* teachings directly into clinical practice. For example, when working with members of multigenerational Navajo households, where elders and young progeny reside in close proximity, Robert encourages patients and their families to conscientiously utilize *k'é* in daily interactions. He tries to persuade key intimates to assume the responsibilities of their kin positions. Accordingly, Robert is affirming to patients his appreciation of Navajo mores:

> Often the mother's brother is an important disciplinarian within traditional families. If you've got a child that is unruly and needs discipline and needs to have parameters set, boundaries set, you might look to the uncle to do that or look to the grandparents to provide some guidance, or inquire into clan relations to find out who else is around. If you can talk in Navajo terms about the people who are around, then I think that lets the patients know that you understand some of these things. (Robert – interview)

Like Robert, most HCS clinicians understood that clan relations provide

invaluable social support for patients. Clan kin often can be relied on to serve as guardians for children whose parents are deceased or otherwise minimally involved in their upbringing. Clan kin also can be called upon for sacred treatment purposes, perhaps to participate in a ceremony. On this count, both professionally and personally, the HCS clinicians were markedly well disposed to beliefs and practices falling in the realm of the Navajo ethnomedical system. Many of them would also turn to Navajo sacred healing to attend to their own healthcare needs.

Elsie, for instance, reflected on her particular experiences as a patient undergoing sacred treatment:

> When I have a ceremony, it's good to see my family, my relations. They are with me and they care for me. They sit up with me all night. Sometimes if they want, they can share songs. They share medication or herbs that they are taking with me. Their thoughts and their thinking are all focused on what kind of problem has been happening – and the prayers and the songs of the Medicine Man – all their thoughts and thinking are going in that direction so they can help me.[17] (Elsie – interview)

HCS clinicians also recognized that clan kin play vital roles in pulling together costly ceremonies. The healer must receive some form of compensation, economic or otherwise, for the ceremony to be efficacious (Aberle, 1966/1982). Additional expenses include food and gifts for persons participating in ceremonial activities. These expenses are typically spread among clan kin, who may donate livestock, groceries, firewood, and other supplies, relieving the patient and immediate family of shouldering the financial burden on their own.

Clinical personnel with lesser degrees of participation in or awareness of Navajo social organization and healing practices tend to be circumspect in their use of the clan system. Moments arise in patient encounters in which it behooves them to defer to coworkers who are knowledgeable about Navajo mores and clanship protocols. During these moments, some clinicians, such as Charlene, become acutely mindful of their own positioning as the cultural other:

> I asked Margaret [Navajo clerical worker] to help with one woman. The woman's granddaughter was half Navajo and half Anglo. Basically what she needed was a ceremony, but this woman said she didn't have anyone to help her. Well, I knew what her clan was. She needed to be confronted about not using her own system of *k'é*, and that needed to come from someone who was Navajo. As it happened, it was real appropriate for Margaret to do that. (Charlene – interview)

Sincere in her attempt to integrate clan support in the patient's healing process, Charlene was willing to dispense with her clinical authority by

deferring to Margaret, who lacked credentials as a trained psychotherapist but was enlisted to function unofficially as an 'ethnic broker' (Santiago-Irizarry, 1993, p. 140), a person of Navajo descent who could combine aspects of Navajo culture in mental health casework. Margaret facilitated the clinical encounter not simply by interpreting for Charlene, but by allowing *k'é* to constitute the basis of her interaction with the grandmother, who was, fortuitously, her clan relative. Charlene further observed:

> From a family systems model the girl was somewhat disenfranchised because she was half white. Grandma was taking care of her but she wasn't. She was complaining that the girl was not traditional. But grandma was not acting or upholding the traditional end of the culture and as a non-Navajo I could not confront that issue with her. Margaret was able to and I think she did that appropriately. And Margaret's parents are both Medicine People. When she was young, folks would come to her house. She would handle their requests for services. So Margaret knows very well how to interview people traditionally in a way that is appropriate and very unique to her position. (Charlene – interview)

Margaret was not treated by either Charlene or the grandmother as an invisible interpreter (Kaufert & Putsch, 1997), or neutral linguistic conduit. She was an active contributor to the clinical process, and was expected to function as such. The intention, shared by Charlene and Margaret, was to persuade the grandmother to explore the therapeutic properties of *k'é* and the Navajo ethnomedical system.

Not every non-Navajo-speaking clinician was as disposed to relinquishing control over patient interactions to clerical personnel, although most of them would actively seek to collaborate on equal footing when working on cases with the Navajo-speaking therapists. Charlene, however, appreciated that Margaret was skillful in interacting with persons in need of ceremonial assistance; she had been interviewing prospective patients for her parents since childhood. However, she was neither a licensed therapist nor trained interpreter. To Charlene's satisfaction, Margaret was adept at operationalizing Navajo cultural frameworks in patient care. But, she was not bound by a code of ethics for interpreters in health care. In addition to preserving patient confidentiality, such codes normally oblige interpreters to abstain from sharing personal opinions and advice and to maintain impartial attitudes towards patients (Kaufert & Putsch, 1997). Charlene's attempt to mobilize the natural supports of Navajo families and communities by soliciting Margaret's assistance constitutes a transgression of codified professional ethics. Yet, one also could argue that this attempt represents a situational strategy – a pragmatic and culturally relevant response to clinically pertinent issues that surfaced in the context of the practitioner–patient encounter.

Taboo in Therapeutic Contexts: The Diagnostic Implications of Clan Incest

> The relationship system of the white people just goes a little way. Their relationship system does not go far, and it continues for only a few generations. They go by the blood. That is not the way with the Navajos. That system was never heard of among the Navajos. (Preston, 1954: 26)

Clinical issues surrounding incestuous relations between clan relatives occasionally surface in the formal patient presentations delivered weekly at HCS case conference meetings. Clinicians and their Navajo patients might analyze such infractions as sources of emotional distress. As noted by Kluckhohn and Leighton (1946/1974), persons involved in incestuous clan relations may be suspected of witchcraft and are considered either insane or doomed to become insane.[18] The traditionally minded Navajo clinicians at HCS concurred that the highly structured clan system was created by the *Diyin Dine'é* to prevent incest and 'intermarriage' between siblings and other relatives. Yet Jake, a Navajo case manager, alleged that the system no longer fills this function:

> People that are related to you, like let's say by clan, like a sister . . . Now they're not supposed to intermarry. But nowadays no one uses that system. I think they're more or less oriented toward the Anglo type of clan system where if somebody's blood related and like a cousin, then you don't marry. To a lot of Navajos nowadays, that's acceptable. (Jake – interview)

In contrast, suggesting that the incest taboo is still a salient feature of Navajo lifeworlds, Elsie elaborated on the case of a middle-aged patient who was distraught over her daughter's intimate relationship with a clan relative. The situation was causing significant tension in the family, which the patient was unsure how to handle. The daughter and her boyfriend did not look upon their behavior as problematic and decided to ignore well-known taboo restrictions. Members of the patient's extended family, who were pressuring the patient to terminate the daughter's relationship, did not overlook this breach. Elsie said the visit to HCS provided an opportunity to confront feelings of embarrassment that were taking a toll on the patient and to finally admit to a similar taboo violation that had occurred in this patient's own past.

At another case conference meeting, Elsie recounted the case a fifty-year old woman diagnosed with post-traumatic stress disorder. The woman had been sexually abused and neglected as a child. Wanting 'worms cleaned out of her stomach,' she had sought help from the physicians at the IHS hospital:

> The physicians kept checking her out, doing all kinds of X-rays and everything, and told her that maybe she needs to come to Mental Health. By the

> time of her intake, we found out that there was incest by her uncle. We talked about that and her anger about that and neglect from her mom and having no guidance or any kind of teaching in the traditional way . . . She said, 'I don't feel good about myself. I think I'm losing my mind. I think I'm going crazy. I think about those things my uncle did to me and probably to my older sisters. And I tried to get some Native American Church help yet these things continue to stay with me. I can't get rid of it and I want to get over it.' (Elsie – staff discussion)

Initially, the patient's physicians took seriously her complaints of worms, but later dismissed them, having discovered no clear physiological signs of disease. Elsie indicated that such complaints are neither bizarre nor idiosyncratic to the individual. Nesting the themes of stomach worms and insanity, the complaints are evocative and culturally meaningful within the contexts of Navajo society, kinship, and sacred medicine.[19] In both case presentations, Elsie's interpretations are influenced by an understanding of etiological considerations that is rooted in the Navajo Way. As she is able to distinguish local idioms of distress that stem from taboo breaches, Elsie's presentations underscore the importance of recognizing the relevance of *k'é* and clan in identifying and analyzing patient problems.

Concerns about the current significance of *k'é* are expressed in clinic talk with frequency. Psychological distress, family dysfunction, and other forms of social discord are often attributed to the fact that Navajos are not observing *k'é* in their daily interactions. Family therapy offers one forum in which patients and kin can contemplate solutions for *k'é* infractions. Because such solutions customarily involve sacred healing interventions, some Navajo clinicians prefer directing patients to resources outside the medical setting. While it is not uncommon for Navajo clinicians to refer their patients to Medicine People, one Navajo clinician would take on the role of relative if patients lacked social support. She would even help to organize ceremonies for them. Navajo and Anglo clinicians also would refer patients and relatives unable to resolve interpersonal tensions to the local peacemaking court, an institution that uses Navajo common law and philosophy to mediate intra- and intergroup disputes. Most specifically, the peacemaking court invites aggrieved parties to make amends by observing the rules of social conduct embodied in *k'é* (Bluehorse & Zion, 1996).

Although the clinicians are amenable to helping patients repair rifts in extended family systems, occasions arise in which they are less inclined to pursue this option. Cases of sexual abuse of children by kin are especially challenging, as the short-term resolution of such situations can contribute to further family breakdown. In order to keep them apart from their assailants, the children may be removed from the only homes they have ever known. Clinicians also observe that the local legal system tends to

promote family reunification prematurely, reintroducing children into environments in which the risk of sexual abuse remains.

The cultural association between sexual abuse and witchcraft complicates how such cases are handled. The belief that family members who sexually abuse kin also practice witchcraft is strong in Navajo society. One Navajo clinician claimed that Navajo court officials, tribal social workers, and IHS personnel are often 'afraid of taking on such cases.' They fear retaliation, including the possibility of losing a life – if not their own, then of someone close to them – if they assume adversarial roles against families that engage in witchcraft. A second Navajo clinician cited the case of an adolescent female undergoing mental health treatment at another IHS counseling center. Bounced from therapist to therapist, the patient had an extensive history of sexual abuse that the center's Navajo clinicians had surmised was linked to witchcraft. Her family was 'known' for its ongoing involvement in witchcraft. The clinicians also suspected that the patient had participated in witchcraft ceremonies. Such suspicions contributed to the Navajo clinicians' reluctance to work closely with the patient and her family.

The Broader Significance of Clan and *K'é* in Clinic Work

Issues relating to *k'é* are an omnipresent feature in clinic work. The exchange of clan introductions in the clinic necessitates that the HCS therapists contemplate their own positions in relation to the social identities of their patients. For some Navajo clinicians this practice of performing 'tradition' is rife with special complications, mainly because it forces them to compromise their own privacy. At the same time, these same clinicians understand the value that resides in clan introductions. Most obviously, while enabling the clinicians to interact with patients in a culturally meaningful manner, this practice affirms that the patient is not an autonomous entity unto itself but is instead a member of much larger social unit – the clan – the members of which can be roused to participate in the therapeutic process. The development of *k'é* relations also serves to satisfy important clinical goals, functioning as a utilitarian strategy to put Navajo patients at ease in the medical setting, while potentially enhancing the clinician's understanding of the patient's upbringing and cultural identity.

Although *k'é* is configured in practitioner–patient interactions as a hybrid form of clinical praxis, the actual value of *k'é* in the lifeworlds of staff must not be overlooked. Some Navajo clinicians observed that clanship and its derivations of kin-based humor appreciably impact intrastaff interactions. Sarah noted:

> Some of us [who work at HCS] are clan related . . . Sometimes it's good because when it's appropriate you can use the traditional joking with those clan members. You wouldn't feel like you're offending that person as long as that person has the feeling that this is based on clan. You say, 'You're my cousin so I'll tease you this way.' Or 'You're my sister.' Like with Shirley [Navajo social worker], she's my sister, so I'll tease her a lot and we're all more direct in our teasing. Even with Charlene, who is not Navajo. We call her sister so we can say [things] the same way as you would with a sister, and I think she's pretty understanding of that and is not offended by a lot of the stuff we say. And she feels the same way. She can say things the same way. (Sarah – interview)

While 'traditional joking' and 'teasing' might aid in alleviating personal conflict among HCS staff, it would be misleading to depict the clinicians as comprising one big happy family. On those occasions in which work-related stress had reached acute levels and intrastaff friction was particularly high, the clinicians would identify themselves collectively as the members of a dysfunctional family.

However, the Navajo and non-Navajo clinicians would again and again sustain group conversations relating to *k'é* when reflecting upon interpersonal animosities among the ethnically diverse staff at HCS. This indicates that they do not delimit the import of *k'é* to patient encounters. In particular, by emphasizing the relatedness of practitioners, *k'é* continues to contribute to the validation and the reproduction of Navajo ethnicity in the HCS setting. Irene explained:

> *K'é* is kind of like being a Navajo . . . Like people say, 'Navajo culture' or 'Navajo religion.' To me that's who you are – a religion. The religion. The culture. The language. And *k'é* comes with it. That's who you are as a person. So it's always part of you. It's how you interact with another person. How you respect that person. And how you communicate with that person. (Irene – interview)

Acknowledgments of *k'é* among staff offer a means for mending tensions and affirming Navajo cultural identity. They also aid in forging affective solidarities among all HCS clinicians, drawing non-Navajos into the Navajo social universe.

Relatedness among colleagues can have subtle effects on workplace politics. For example, since its inception in the 1970s, the persons commonly residing atop the clinic's leadership hierarchy have been Anglo psychiatrists.[20] Navajos have occupied lower-level positions, which restrict their capacity to exert formally administrative and clinical authority. Navajo personnel urged a qualified Navajo social worker to apply for the clinic's directorship, but this individual was resistant to the idea, concerned that he would be swamped by bureaucratic responsibilities. Some staff

speculated that by virtue of being Navajo, this person would have a hard time asserting himself as director among Navajo co-workers, who could take advantage of him by invoking clan obligations. Such a speculation may not be baseless, as suggested in my conversations with employees of tribal health and social service programs. Navajo personnel largely staff such programs.

A Navajo supervisor of one such program spoke of how clan ties contribute to workplace tensions, revealing that a clan mother had accused him of insolent behavior after he criticized her job performance. She commented that the Creator would condemn him for his disrespect. In a related example, the same supervisor decided to consult a Medicine Person after a series of life-threatening mishaps had befallen him. The Medicine Man divined that the supervisor was the victim of witchcraft, which had been initiated by a disgruntled ex-employee – an older clan relative, no less – who was dismissed for insubordination.[21]

Termination processes are far from casual occurrences in tribal programs. Tribal employees are 'disciplined' if they are clearly not performing up to expectations or have repeatedly violated the rules of the workplace. Disciplining entails a three-tiered process of written reprimands or warnings, suspension, and possible termination. An employee, however, can appeal against penalizing action through official channels. The Navajo supervisor told me that he does not relish the duty of disciplining his co-workers. He also fretted over the way the execution of this responsibility compels him to sully the behavioral code of *k'é*:

> As a supervisor doing my work, the *k'é* sometimes causes conflict for me. Going back to the teachings of my parents, I was taught to be respectful of my elders, particularly those elders who are members of my mother's or my father's clan. The clan part does tend to override some of the decisions that I make, but when I'm supervising someone, I try to take the *k'é* part out of there. Disciplining is like disrespecting that person. Disrespecting my elders is difficult, but I have to do it. If it's a younger person or someone my age, I don't think I really have a problem with disciplining them . . . I play two roles: Being a Navajo and utilizing the clanship and being in the dominant society, where I have to discipline employees as part of my job. In the end, I have to associate my decision with my job. At the same time, when the person who has been disciplined returns to work, I'll still treat them as my mother or father – as clan relatives. The *k'é* gets intertwined in my work again. (Navajo supervisor – interview)

The challenges articulated above are not unique to this supervisor. It is no simple matter to either sustain or to disengage *k'é* connections in the workplace.

Discussion: The Ethical Implications of Clan Relatedness in Clinic Work

K'é continually inspires many of the clinic's Navajo and Anglo providers to explore their personal relationships with coworkers and patients. The existence of overlapping social relationships involving clan linkages is particularly disconcerting to those Navajo clinicians at HCS who are concerned about the implications of identifying patients as relatives. For these Navajo clinicians, all of whom have been trained to uphold the epistemological and ethical tenets of a Euro-American ethnopsychiatric system, this acknowledgment of clan relatedness symbolizes an acknowledgment of Navajo cultural standards; yet this act also results in violating their 'felt sense of professional standards' (Zussman, 2000).

From the ethical perspective that predominates in the Euro-American mental health disciplines, the dual relationships deriving from clan linkages can be construed as conflict of interests that potentially disrupt the maintenance of appropriate treatment boundaries. For example, referring to one's patient as one's parent, sibling, or child can be exploitative, unduly increasing the clinician's influence over the patient, or vice versa. Conversely, dual relationships could support therapeutic alliances in a culturally affirmative manner, while strengthening the desire of patients to adhere to the counsel of their clinicians.

However, attempts to create culturally relevant spaces in which to render mental health services can backfire, alienating those Navajo patients whose self-perceived social identities are independent from clan and kin taxonomy. Some patients resent the well-intentioned invocation of clanship, interpreting this act as an unwelcome effort to incorporate the Navajo Way into clinical encounters. Alternatively, the clinician's demonstration of cultural knowledge can intensify the worries of some Navajo patients. For example, persons intimately involved with clan kin may be anxious over the clinician's apparent understanding of Navajo tradition, anticipating that it will play a role in condemnatory interpretations of their lifestyles and presenting problems. Other patients may become troubled over confidentiality breaches, imagining that the clinicians might gossip about their problems with 'relatives.'

The Navajo clinicians would frequently characterize themselves as straddling two very distinct lifeworlds – the 'culture' of the Navajo and the 'culture' of the *bilagáana*. They work in a medical setting in which they are obliged to uphold ethical principles and professional values that do not always coalesce with the principles and values of the surrounding Navajo community. Indeed, as Sarah had pointed out, behaviors and actions perceived to be ethical violations in the White Man's Way are not necessarily synonymous with or comparable with behaviors and actions

considered to be ethical violations in the Navajo Way (cf. Carrese & Rhodes, 1995). Recognizing the salience of clan introductions and of clan identities within this medical setting helps illuminate the clinical complexities involved in straddling two lifeworlds.

The clinician's decision to acknowledge clanship ties in mental health practice should not rest on a priori assumptions about the preferred mode of social interaction of Navajo patients. Because the use of the clan introduction has a situational value, I also would caution against incorporating clanship protocols into formulaic clinical guidelines. The HCS clinicians and other Navajo providers have argued that the recognition of overlapping social roles can, at times, adversely affect their work with clients, or have little impact on the way specific cases are handled. However, when clanship ties are invoked pragmatically and conscientiously, many of these same individuals maintain that the creation of kin-based alliances can positively shape therapeutic contexts.

An ethical approach to counseling in cross-cultural settings must take into account the benefits and dilemmas that surround the seemingly innocuous use of a normative Navajo cultural practice in mental health work. For instance, is the clinician treading a fine line when referring to an elderly patient as a grandparent in order to garner this patient's trust? Is such conduct controlling? Or does such conduct support the therapeutic relationship and validate the patient's sense of personhood in a culturally meaningful manner? Moreover, what are the implications of clan invocations for the clinicians? Such questions will hopefully stimulate clinicians and anthropologists alike to reflect upon the more subtle and elusive implications of developing and operationalizing culturally relevant care.

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Notes

1. Persons designated as Navajo refer to themselves as *Diné*, which means 'The People.'
2. 'Hózhóógo naasháa doo' means 'I will walk in beauty.' 'Hózhóógo Naasháa Doo Counseling Services' is a pseudonym. Throughout this article, I use pseudonyms when referring to place names and individual HCS clinicians. HCS is in the Four Corners of the Southwest, a diverse topographic and

polycultural region that is marked by the geographical intersection of Arizona, New Mexico, Utah, and Colorado. Between January 1996 and July 1997, I conducted ethnographic fieldwork in this region. Employing methods of participant observation and focused interviewing, I examined issues of cross-cultural mental health delivery from the perspectives of IHS clinicians who work in 'Tsé Łizhin' or 'Black Rock,' a town in the upper east periphery of the Navajo Nation. With an estimated catchment area of 50,000 people, most Navajo people in the Four Corners are served by the IHS hospital in Tsé Łizhin, which is where HCS is housed.

3. The clan system enables the Navajo to trace their ancestry directly to the *Diyin Dine'é* (Reichard, 1950), the creators of the *Nihookáá' Dine'é* or Earth Surface People. The *Nihookáá' Dine'é* evolved from the insect-like *Nílch'i Dine'é* or Air Spirit People. Linkages between the *Diyin Dine'é* and *Nihookáá' Dine'é* are delineated in the Navajo creation story (Goddard, 1933; Levy, 1998; O'Byran, 1956; Spencer, 1947; Yazzie, 1971; Zolbrod, 1984). This story describes the emergence of the *Nílch'i Dine'é* from a place deep within the earth, detailing the challenges they endured as they climbed through four subterranean worlds, making their way to this world's surface, where they matured into humans. Levy (1998) argues that the Navajo adopted clans only after they had migrated to the Southwest some five centuries ago. For the purposes of this article, I am inclined to accept the view espoused by many Navajo and non-Navajo clinicians at HCS – a view in which clans are the handiwork of the *Diyin Dine'é*.
4. For decades, the Navajo clan system has been the subject of intense anthropological scrutiny (Aberle, 1961; Kluckhohn & Leighton, 1946/1974; Lamphere, 1977; Reichard, 1928; Shepardson & Hammond, 1970). Navajo clans have been described as mechanisms of social control, which, in the past, deterred deviant behavior: 'All clansmen were responsible for the crimes and debts of other members of their clan, hence it was in their own interest to prevent murder, rape, and theft on the part of any and all clan relatives' (Kluckhohn & Leighton, 1946/1974, p. 112–113). While emphasizing that clan bonds entail hospitality, economic and other reciprocities, anthropologists typically highlights the role that clan exogamy plays in limiting marriage choices. Generally depicted as unorganized entities, clans, which can consist of several thousand persons dispersed geographically, lack formalized leadership structures and do not serve authoritative functions (Aberle, 1961). Although clans are not ranked in terms of political or economic might, members do not shy away from expressing pride in their clans. Accentuating the importance of the maternal clan in defining one's primary descent identity, some Navajos today display bumper stickers on their vehicles that declare to which clan the driver is *born of*.
5. See Witherspoon (1975, 1977) for detailed analysis of Navajo social organization and the multiple descent groups to which an individual belongs.
6. Biomedicine, which encompasses the mental health disciplines, is one component of the Navajo Nation's pluralistic healthcare system. Navajo people experiencing emotional or physical distress have a variety of places and people they can turn to for help. One morning while we traveled to a patient's

home, Jake, a Navajo case manager, spoke of diversity in Navajo healing practices. Our discussion was precipitated by his recollection of a conversation with a client. Jake had inquired into the client's activities over an extended holiday weekend. The client told Jake that she went to a Christian tent revival from Thursday to Saturday, consulted a Navajo stargazer or diagnostician on Sunday, and sought services from the IHS on Monday. Jake chuckled as he recounted the client's response – a response that aptly captures the highly syncretic nature of the Navajo healthcare system. Although this article is only tangentially concerned with how the varying healing epistemologies of the long-established Navajo ceremonial system, the Native American Church, and Christian denominations are combined daily by the Navajo persons who use them (Finkler, 1994), I include Jake's comments to underscore that Navajos neither uniformly rely on nor necessarily resort to biomedicine, or secular healing, to either explicate or remedy their health problems (Csordas, 2000; Csordas & Garrity, 1994; Kunitz & Levy, 1981).

7. See note 3.
8. In their discussion of the Navajo-Cornell Field Health Research Project, Adair, Deuschle, and Barnett (1972/1988) recount the creation of an innovative cross-cultural approach to medical files in which the collection of patients' clan designations figured prominently. Navajo clerks were reluctant to obtain clan information from Navajo patients presenting in clinics, social spaces belonging to 'the white man's world,' and were themselves ashamed of the clan system. Their reluctance is attributed to the past experiences of the clerks with 'white administrators and teachers' who had scoffed at Navajo cultural institutions. The clerks became more disposed to inquire into patients' clans once they determined that the project's Anglo clinicians and researchers did not view clans as curiosities (Adair et al., 1972/1988).
9. Notions of *k'é* are nested in constructions of 'tradition.' These constructions underlie the frequently essentialized conceptualizations of Navajo culture that are mobilized in clinic work. In their descriptions of Navajo culture, HCS staff would allude to a homogenizing matrix of core attributes or traits. This matrix consists of numerous shared traditions relating to Navajo language utilization, spiritual beliefs and practices, certain forms of everyday attire, subsistence occupations, and overall lifestyle. While these constructions of tradition reflect the ordinary vernacular of clinic and community discourse, not one clinician would assert a dominant or an authoritative view of Navajo culture. The clinicians would instead invoke tradition in a remarkably flexible manner, arguing that it is not monolithically constituted as an unchanging or bounded set of doctrines or practices, and does not foreordain the cultural or ethnic identities of Navajo people.
10. The following is an alphabetical list of selected HCS staff members, including their position titles and self-described ethnic categorizations.

Name	*Position*	*Ethnicity*
Charlene	Psychologist	Anglo
Elsie	Mental health specialist	Navajo
Emily	Psychiatrist	Navajo/Anglo

Name	*Position*	*Ethnicity*
Gerald	Psychiatrist	Anglo
Irene	Psychologist	Navajo
Jake	Case manager	Navajo
Lauren	Mental health social worker	Navajo
Margaret	Clerical worker	Navajo
Priscilla	Medical social worker	Navajo
Robert	Psychiatrist	Anglo
Sarah	Mental health social worker	Navajo
Shirley	Medical social worker	Navajo

11. As speakers of Athabascan languages, Navajo and Apache peoples are linguistic kin. It is beyond the scope of this article to explicate how the social and linguistic histories of the Navajo and the Apache converge and diverge. However, it is important to note that many Navajos, such as Priscilla, distinguish clear links between the Navajo and the Apache. The Mescalero Apache, for instance, are referred to as members of an adopted clan called *Nashgalí Dine'é*. Over the centuries, the Navajos also have incorporated several neighboring populations in the Southwest into the clan system. The expression, *Naakaii Dine'é*, for example, refers to the 'Mexican clan.' Clan designations also are applied to persons of particular European ancestries.
12. See Farella (1984) for critique of Witherspoon's (1977, 1983) explication of *hózhó*. As Witherspoon's conceptualization of both *hózhó* and *k'é* closely resembles statements articulated by the HCS clinicians and other Navajo informants, I find his work quite useful in framing this discussion of practitioner–patient clan relatedness.
13. *K'é* is a general concept of solidarity that encompasses an assemblage of positive virtues that one strives to observe in all social relationships. *K'é*, however, may be felt more strongly when one 'goes down the taxonomy of one's own people, one's own clan, one's own family, and eventually, one's own mother' (Witherspoon, 1975, p. 120). *K'éí* is a special kind of *k'é* that is based in lineage. The term *shik'éí* ('my relatives by birth or clan reckonings'), for instance, identifies an exclusive group of people with whom an individual will especially relate in accordance with *k'é* (Witherspoon, 1975).
14. Gerald's views are influenced by biomedical constructions of borderline personality disorders. Patients diagnosed with such conditions reputedly vacillate between idealizing and devaluing their therapists (APA, 1994), and interact with therapists in ways that provoke adverse countertransference reactions, including frustration, guilt, rescue fantasies, rage and resentment (Gabbard & Wilkinson, 1994).
15. Charlene's clan greeting corresponds closely to the prescriptive steps outlined by instructors of preparative Navajo language courses, which are taught at the local community college. Although Navajos will generally refer to their maternal clans and then their paternal matrilineal clans when introducing themselves, Anglos are advised to designate their maternal clans only, commonly delineating these clans as *bilagáana*. If one specifies one's maternal and paternal matrilineal clans as *bilagáana*, one thereby implies that one is the

product of an incestuous union. However, when introducing herself to Navajo patients, Charlene does not identify herself singularly as *bilagáana*. She refers to her adopted Navajo clan and her own ancestral European ethnicities, speaking basic Navajo with a slight Southern twang. She uses local nomenclature, referring to her beloved farm animals by their Navajo names and setting them apart as members of her own extended family. This insertion of whimsicality into a highly stylized and creolized brand of clan introduction often induces Charlene's Navajo interlocutors to giggle, diffusing the fear and apprehension that might pollute the air of the intake. Importantly, this insertion is neither parodic nor satiric in its effect, but is instead usually received as a display of deference from an Anglo medical professional.

16. The primary context for disseminating teachings of *k'é* and clan has been transferred from family settings to institutional settings. Within elementary schools, secondary schools and colleges, many Navajo students are learning for the first time about their own clans as well as their 'relatedness' to others. In the classroom venue, they are exposed to standardized curricula that emphasize the significance of clan identity in contemporary Navajo society.
17. This emphasis on the 'power of thought' informs constructions of illness and sacred healing: if one thinks of good things and of good fortune, good things will happen; if one thinks bad things, bad fortunes will occur. By cultivating the 'power of thought,' ceremonies are intended to cure and bless patients in order to restore their health and happiness (Witherspoon, 1983).
18. Reichard (1950, p. 405) suggests that moths are symbols of temptation and foolishness among the Navajo; the expression 'acting like a moth' signifies insanity resulting from incest. Referring to *iich'hą́ą́* or 'moth madness' (Levy et al., 1987), Aronilth (1991, p. 128), a Navajo philosopher, writes: 'Our grandparents' belief was that we must not marry within your own clan or with your blood relatives. You cannot marry your mother's or father's clan. If you marry into your own clan, it will affect your mind, breathing, attitude, your spiritual being and your mental being. All of this will begin to destroy and change you slowly. From some of these mistakes, the results would be like the action of a moth. You would run or jump into the fire. Some of these mistakes develop into stomach worms that lead to cancer. Birth defects would begin to show and sores would develop on the children's bodies. For these reasons, it is important to teach the right way of the clan system.' A Navajo clinician said that the incest prohibition constrains physical interactions among siblings: 'When I was little, I asked my mother, "What do you mean by *iich'hą́ą́*?" She said, "Do you see the fire and the moths flying around the fire? That will happen to you if you touch your brother or sister. You'll go crazy. The fire will hypnotize you, mesmerize you and pull you in. You won't have control of you're mind. The fire will." So it was hard for me to touch or to even hug my brothers because that was instilled at an early age.'
19. Elsie met regularly with this patient every two weeks for a total of nine sessions: 'The worms disappeared after I think the third session. And that's part of the incest, I guess, that she was thinking of all the things she was doing wrong. And she felt so bad because she thought that was normal. And she grew up thinking that was normal, that families did that to each other.' Elsie also

observed that the patient 'would feel really good' and 'real happy' each time she had a Native American Church ceremony, but she continued to experience ruminations relating to the incest. These ruminations subsided over the course of mental health treatment. Elsie explained, 'We imagined her talking to her mom because she was never able to tell her mom what her uncle had done to her and she wanted her mom to know, but her mom was dead. So she was able to tell her mom's spirit. And she felt pretty good about that. And she also had a chance to talk with her uncle . . . She confronted his spirit also. And after that is when she started feeling a whole lot better.' Although the patient's symptoms confounded doctors, who speculated that she suffered from delusions, the post-traumatic stress disorder diagnosis, often applied in sexual abuse cases, facilitated the medicalization of her condition into a problem amenable to mental health treatment. For Elsie, however, the patient's complaints regarding stomach worms and her admission 'I think I'm losing my mind' are significant outside the context of the DSM, viewed as symptoms of an illness diagnosable in the sacred sector. While it is suggested that the patient's lack of teaching in 'the traditional way' did not insulate her from illness originating from the transgression of the incest taboo, what I find striking about this case is Elsie's description of the treatment rendered in the clinic. Involving a form of communion with deceased relatives, this treatment contrasts with the stereotyped view that Navajos consider spirits to be malevolent and dangerous, and will thus refrain from speaking or thinking about lost relatives for fear that the dead might pay an unwanted visit.

20. See Willging (1999) for discussion of ethnically stratified hierarchy in the IHS and its impact on interethnic staff relations in the HCS setting.
21. Clan kin accusing relatives of witchcraft is not unprecedented (Kluckhohn, 1944), although I would say that it is more common for HCS clinicians to encounter patient witchcraft complaints involving biological kinfolk. Such complaints often arise in contexts of land disputes.

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