The first chapter discussed the hypothetical formula for prioritizing mental health services. The following chapters defined some of the mental health problems affecting Indian people. There followed a look at the impacts that these problems are thought to have on Indian communities, and a discussion of a theoretical framework for considering these interventions in treatment and prevention services. The reader is encouraged to be familiar with the disorders discussed in Chapter II, to have an idea of how these disorders may be affecting his or her community, and to be thinking about the type of program structure needed to begin to treat the problems. For example, is an early identification and screening program effective for a very wide-spread mental illness, or is the problem an uncommon one with a costly chronic course, that is perhaps better suited to a rehabilitation-type program? Is the best structure a JCAH-like program, or does the nature of the population and the pattern of illness suggest that a better mental health system would resemble the Chinese model?

In this chapter, we begin to examine treatment tools for the major mental health problems of American Indians on a more microscopic, case-level basis. In later chapters, we will examine the immediate details of getting these specific interventions to the individual patient.

In planning mental health programs, it is vital to be aware of the range of therapeutic modalities, prevention techniques, and rehabilitative methods available. The thinking about the effectiveness of various forms of treatment changes in the field of mental health over time must be understood. Beliefs about the effectiveness of a particular form of therapy change over time, in relation to scientific findings about the illness, to outcome studies on a particular form of therapy, and to the national or world-wide consensus of practitioners and academicians about these therapies. In many cases, forms of therapy that were once popular now have almost disappeared. Currently, one rarely hears about the therapeutic effects of hydrotherapy or transactional analysis, for example. Increasingly, the rise and fall of therapeutic modalities depends upon the findings of scientific studies of outcome. The discussion of treatment modalities in this chapter cannot be considered to be the "final word." Rather, the reader should be aware that the study of treatment technology is a constantly changing field, with the best thinking of one year being found to be incorrect the next. A good way of keeping up with the changes is to subscribe to one or more of the journals listed in the suggested readings.

One major risk in any mental health program is that the therapeutic techniques used by its staff are ineffective, outdated, or even harmful.
Although this is true for any field of medicine, in mental health programs there is an unusually great tendency for therapeutic modalities that appear to make "common sense" to the practitioner and public to be found to be largely or completely ineffective after millions of dollars have been spent delivering this therapy to the public. In some cases, such as that of replacement of trace minerals resulting from an analysis of the patient's hair, the intention of the provider of this service may be frankly unscientific or even fraudulent. In most cases of ineffective therapies in mental health, however, the people who practice the form of therapy are well-meaning people whose enthusiasm is genuine and who sincerely believe that their form of therapy is the best advance in the field in decades. It may not be easy to tell these sincere therapists that their therapy has not been proven or has been found to be ineffective.

There are probably several reasons for the promulgation of ineffective forms of therapy. Both placebo effect and the power of suggestive techniques have been discussed in another chapter. If patients and other therapists believe very strongly in the effectiveness of a particular form of therapy, it is difficult for any normal therapist to resist joining the enthusiastic throng. Enthusiasm, sincerity, and a model with good "common sense" ideas that conveys a sense of surprise and revelation are elements in any new therapeutic movement. Who would not want to follow a group with such characteristics? Unfortunately, the enthusiasm with which a particular form of therapy is endorsed by its practitioners does not have any relationship to its actual effectiveness.

The phenomena of therapeutic movements are a mixed blessing. Results from any well-intentioned therapeutic movements are often beneficial to patients, either as a result of the placebo effect or as a result of the social interactions with the therapist or group. The therapist or therapeutic group that is convinced of the truth and usefulness of its therapeutic model provides for many people a sense of security and a sense of renewal and enthusiasm for life; it may be stimulus for the patient to solve other problems for which individuals had not previously had sufficient energy. If the basic intentions of any therapeutic movement are good and the methods required for membership in the therapeutic movement are not harmful to a community or to the patient's family, how can the program planner object to such movements too strenuously?

However, it is reasonable to object to therapeutic movements which actively shun scientific studies of outcome or feel no need to prove their "obviously" beneficial results. When studied in a scientific way, some forms of therapy may do nothing or be worse than no intervention, such as the outcome studies which demonstrated that a psychodynamic approach to schizophrenia may be worse than no intervention. Carefully planned and executed scientific studies demonstrate the effectiveness of certain forms of therapy for a particular condition over and above the social and placebo effects of the therapy. As one might imagine, studies to assess such therapeutic effects are difficult to design. Often the design requires that
three groups of patients be used—one with no intervention, one with a placebo intervention, and one with the actual therapeutic intervention—and that results of each intervention be followed closely.

Such studies have demonstrated very interesting findings in the last 10 years. Some forms of therapy appear to be significantly better than others, such as the use of behavioral therapies with phobic conditions or the use of interpersonal and cognitive therapies in depression. In other cases, personal characteristics of the therapist appear to be much more important than the theoretical model of the therapy being used. The warmth, genuineness, and empathy of the therapist appear to be the most significant factors leading to successful therapeutic outcomes in one group of studies. These therapist characteristics were more important than the form of therapy as practiced even by master therapists. The sum of these studies suggests that sometimes the characteristics of the therapist are the most important factor in treatment outcome. In other disorders, very specific therapeutic techniques are far more important than the personal characteristics of the therapist. For example, depression, panic disorder, and phobias seem to require very specific sets of therapeutic skills rather than just a good therapist.

The mental health program planner is faced with several difficult tasks. Public support and testimonials for a particular type of therapy can be expected to be strong for any significant therapeutic movement. At meetings, one will hear testimonials and sense the enthusiasm of a community for a particular therapist or program. Even if the therapeutic approach is unproven, the enthusiasm for it on the part of the therapists and the community is clearly one of the factors in its success or hopes of success. If one questions the value of the therapy in public or too strongly to the therapist, the genuineness and sincerity required of a good therapy may be lost. Even those therapies with demonstrably better-than-placebo outcomes might be ineffective if neither the therapist nor the patient believed in their effectiveness.

In some cases it may be that there are therapists whose personal charisma and other personal leadership characteristics could make almost any form of therapy work. The mental health program director would be foolish, indeed, in correcting the work of such therapists. The only available intervention to the program director is expanding the therapeutic horizons of the gifted therapist to include other therapeutic modalities that actually have more than a placebo effect. In this way, the system of mental health care delivery may take advantage of both the "art" of the naturally skillful therapist and proven superior therapeutic technologies.

It is interesting to note that for a variety of reasons, the therapeutic modalities which have the greatest effectiveness over and above the placebo effect are sometimes the least appealing in the current philosophical climate. The use of medication with some illnesses is the best proven and least dangerous form of intervention available. However, medications are not always popular as a form of treatment in major
depressive episodes. With their risk of premature death, the increased effectiveness of medication over some forms of psychotherapy creates a condition in which treatment with antidepressant medications may be less dangerous than trying to cure the episode with supportive psychotherapy, for example. However, the administrator who tries to get therapists to change their favorite form of psychotherapy for the more regimented and difficult forms of psychotherapy such as cognitive or interpersonal therapy which are effective in depression, or to get non-physician therapists to use medication as a first-line treatment for depression, are likely to encounter stiff resistance.

In working with Indian people, the wise therapist, administrator, or researcher is well advised to remember that the outcomes of therapeutic interventions, including even the effects of suggestion, depend to some extent upon culture. The degree of directness which is socially permissible between therapist and patient varies greatly with culture, as does the culturally-related attraction or abhorrence to a particular style of therapy. For example, clinicians working in Asia maintain that the skilled clinician is expected to be very directive in telling the patient what to do. The Asian patient will use the clinician's conviction as a measure of the correctness of his advice. Among some groups of American Indian people, telling a patient--particularly an elder--what to do very forcefully and directly does not improve cooperation with the therapeutic suggestion and may interfere with it. If a therapist from one culture tries to "sell" the benefits of a particular therapeutic modality to a patient, the "placebo effect" of the suggestion may depend very heavily upon which culture the therapist and patient belong. The effectiveness of a therapeutic suggestion depends upon the framework of belief and custom of both the therapist's and patient's cultures, and the feelings of each person about the culture of the other.

In some cases, Indian people may have been protected from the tides of changing therapeutic movements by a degree of culture-based skepticism. In working with Indian communities, one rarely sees the same therapeutic "fads" come and go as in the non-Indian mental health community. On the other hand, this same skepticism may also prevent some of the more effective but unappealing forms of therapy from being brought to Indian communities. For example, medications are slow to win acceptance as a legitimate form of therapy on some reservations, as are behavioral therapy and some forms of cognitive therapy, in spite of studies demonstrating the effectiveness of these techniques in controlled studies among non-Indians. In other cases, therapeutic fads do occasionally take root on reservations and in spite of good evidence about their ineffectiveness are sometimes very difficult to dislodge. The wide use of vitamins to treat all mental illnesses, started by a woman whom the mental health staff called "vitamin nurse," was a fad on one reservation. Even when it was found that she was making large profits from her sales of vitamins, it was difficult for other providers to convince the community that there was any more effective treatment for their problems.
Although the task of designing and improving mental health programs for Indian people in a world of changing non-Indian mental health technology is a difficult one, some methods of approaching this difficult problem are possible. The administrator/planner may wish to be fairly tolerant of a range of therapies at first, while trying slowly to improve the effectiveness of the treatments offered. In the case of ineffective or fad therapies, too rapid or strong confrontations of therapists or community members may provoke a "backlash" in many Indian communities. In replacing an ineffective therapy with an effective one, the planner is well advised to be subtle, sending the therapist to training programs where more effective forms of therapy are taught, bringing in outside consultants, or even sending community members to conferences to learn about effective forms of therapy. Strong and concrete ethical boundaries of therapeutic modalities must be formulated for all therapies, however. Certain forms of supposed therapeutic intervention (such as having sex with patients, or assaulting or severely humiliating patients) and therapeutic approaches which encourage dropping a proven effective form of therapy in favor of an unproven form (such as giving up medications in favor of hypnotic reincarnation therapy for depression) are potentially harmful to patients and must be controlled.

In order to assure quality in the mental health care delivery system, the administrator/manager of the system must stay apprised of new and effective trends in all available areas of treatment. A staff of therapists must have their horizons continually expanded in order to be gently informed when new techniques may be more effective than techniques they are using. The goal is not to convince therapists, patients, or communities that the old techniques are ineffective, even though the studies may show them to be, but rather to convince them that the new approaches may be even better.

A bewildering array of therapeutic interventions are in use in the United States today. Although it would be ideal to be familiar with each school of therapy, the health system planner would find this an impossible task. Rather, understanding the major categories of approaches to therapy, some typical forms of therapy under each category, and the strengths and liabilities of each major approach may be the most effective kind of information to consider in planning broadly based mental health program.

**Psychopharmacology**

The use of medications for the treatment of certain mental health problems is called "psychopharmacology." Used correctly and effectively, medications may be among the most effective, easiest, and least costly forms of treatment of some of the major mental health problems facing Indian and non-Indian communities. Used ineffectively, medications may cause major problems in the form of side effects, may hinder rather than
help the patient, and may create mistrust of all treatments on the part of the patient population.

Medications have been little short of miraculous in their contribution to mental health. In the 1950s, drugs like Thorazine created a revolution in the treatment of psychosis. Hospitals which had populations of up to 100,000 in some cases were almost emptied over a very short period as patients were returned to their families and communities. The economic benefit of these medications to the United States alone has been in the billions of dollars.

On the other hand, the misuse of medications that influence mental functioning is a problem of equally staggering proportions. In almost any town, sedative hypnotic and psychomotor stimulant medications find their way from the prescription pad onto the streets. Everyone knows someone who has become habituated to or has had unpleasant side effects from a psychotropic medication. There can be little doubt why feelings about psychotropic medications run so strongly or why there is such a diversity of opinion about the use of these medications.

To avoid such factional considerations, the planner or clinician is well advised to consider medication from the point of view of the patient. Tort law suggests an interesting solution to the problems of the use of medications in the form of "informed consent." If the clinician is well informed about the use of medications and can explain the potential risks and benefits of the medications to the patient, the patient can make an informed decision about whether to utilize medications or any form of therapy. The patient also needs to be informed about the risks and likely result of the illness, both with and without treatment. The need for accurate information for patients is yet another reason that it is vital to maintain a high level of staff training in the basics of mental illnesses and their treatment.

In considering psychotropic medications, one further examination of attitudes is needed. The viewpoint that all medications are "bad" is a philosophical stand rather than the result of data in the real world. Likewise, those who believe that medications are the solution to all problems in mental health are likely to be mistaken for at least the next century. Neither of these extreme points of view represents reality better than the other. The astute planner will recognize that each category of medications has its own strengths and weaknesses and will act accordingly.

**Neuroleptics**

This group of medications is also known as "major tranquilizers." It contains such medications as Thorazine, Haldol, Prollixin, and Mellaril. When these medications were first released, they provided the miraculous reduction in the number of hospitalized psychiatric patients in the United States, and they continue to be the treatment choice for a number of psychotic conditions which otherwise could not be managed.
For many years it was thought that these medications exerted their effects through the blockade of dopamine receptors in the brain. In fact, for decades all the known neuroleptics had the property of blocking dopamine receptors. More recently, however, antipsychotic medications have been found that do not appear to work directly upon dopamine systems in the brain. They are very effective in reducing psychotic symptoms such as hallucinations and delusions.

The side effects of all these medications are significant. The sedation they cause is recognized as a side effect rather than as a part of their therapeutic properties. In addition, dopamine (the chemical affected by neuroleptics) is involved in many of the patterns of physical movement controlled by the brain. It has been found that these medicines have both long-term and short-term side effects upon these systems of the brain which control physical movement. Of these movement disorders, tardive dyskinesia, a serious problem of involuntary movements such as chewing or facial grimacing, is by far the most serious consequence of the long-term use of these medications. With years of use, a high percentage of patients taking these medications develop this movement problem.

Although known as "major tranquilizers," these medications have the effect of reducing psychotic symptoms quickly and effectively; they are not really "tranquilizers" except as a side effect. Because of their risks, they are not appropriate for use in panic, anxiety, or sleep problems. When neuroleptics must be used, it is important that the patient receive periodic evaluations for tardive dyskinesia and other serious symptoms. This evaluation must be performed by someone who has been trained to perform the evaluation.

It has been found that risks for tardive dyskinesia are related to the total amount of medication taken over the years. It is important, therefore, that the patient's psychiatric needs be carefully balanced against the risks of high doses of these medications. Although high doses of neuroleptics were used for many years on the theory that high doses were faster and more powerful in relieving psychotic symptoms, recently it has been found that low doses may be more effective. This is the result of a "window effect" by which both doses that are too high and too low produce less than optimum effects. Nowadays, doses less than one-fifth than those common a decade ago are in use in the treatment of schizophrenia.

Although there are risks to the use of neuroleptics, the high levels of death and disability from untreated psychotic symptoms makes their use mandatory in some cases. Psychotic conditions such as schizophrenia, mania, psychotic depression, and certain organic mental disorders are still best treated with neuroleptics in addition to supportive and rehabilitative efforts. Without medication treatment these conditions carry a high rate of death and disability. In addition, Tourette's Disorder, a condition in which the sufferer experiences involuntary grunts, cries, and involuntary swearing is appropriately treated with neuroleptics. If the patient does not suffer from one of these conditions, the use of neuroleptics is questionable at best.
Patients taking neuroleptics must have their diagnoses reviewed at periodic intervals to make sure that the use of these drugs is appropriate.

### Antidepressants

For Indian people today, antidepressants may be one of the most potentially beneficial and under-utilized treatment technologies. The significance of major depressive episodes appears to be substantial in Indian communities, causing substantial disability and loss of life. The effectiveness and relative safety of these medications in comparison to the probable impact on the morbidity and mortality in Indian communities makes it essential that these medications be used effectively.

If used effectively, these antidepressant medications are over twice as effective as placebo or simple supportive psychotherapy. If used in combination with interpersonal and cognitive therapy, they rate among the more effective treatments in mental health. However, their effectiveness depends upon their appropriate use.

Unfortunately, the use of these medications is difficult for most Indian mental health programs. Patients often find them uncomfortable, and in the typical thinking pattern of depressed people, tend to feel guilty about needing a "crutch" to overcome depression. In addition, the use of the older medications of this group causes a high level of side effects which make it difficult for patients to take the medications for a long enough time for them to work. Practitioners also seem to have an unusually difficult time prescribing and monitoring these medications in the most effective ways. As a result, the potential for the appropriate uses of antidepressants has not been fully realized.

The oldest group of antidepressant medications is the "tertiary amine" group. This group was the first released for general use, and includes such medications as Tofranil, Sinequan, and Elavil. This group is effective but has a high level of side effects, which make it difficult for patients to use them for the required two or three weeks before the onset of their therapeutic effects. These medications affect a number of types of receptors in the brain, although it is thought that they help to treat depression through their effects upon the chemicals serotonin and norepinephrine. However, they also block acetylcholine and are potent antihistamines. This antihistamine effect is largely responsible for the sedation that is a troublesome problem associated with these older medications. Other side effects include a variety of problems ranging from blurred vision to some effects upon the conducting system of the heart. It has been found that in order for these medications to be effective, a minimum, critical level must be present in the bloodstream. Most patients require between 150 mg and 225 mg per day of these older antidepressants to obtain an effective blood level. Perhaps because of the sedation from the antihistamine effects, some clinicians incorrectly believe that grossly sub-therapeutic doses such as 25 mg to 75 mg are enough for patients.
Tertiary amines have been used for several decades without serious long-term consequences. However, because of the uncomfortable side effects and the length of time that it takes for them to work, it is often difficult to get patients to stay on the medications long enough to get a therapeutic effect. These medications may be less effective in several ways than the newer medications, but since they are older, their patents have expired and they are inexpensive.

The next generation of antidepressants included drugs that were the secondary metabolites of the first medications. These "secondary amine" medications work much like the older tertiary amines, but at lower doses and with significantly reduced side effects. Medications in this group include Pamelor and Norpramin. It is not uncommon for patients in whom side effects of the older medications prevented obtaining an adequate dose to feel comfortable enough with the second generation medications to achieve a therapeutic effect. There are still some characteristic side effects, however, and the financial costs of these medications are significantly higher than older medications.

There is now another new generation of antidepressants that work in ways that are very different than the older medications. Some work on entirely different receptor populations in the brain. Some work on the re-uptake of serotonin in the brain and some on the central alpha2 receptor. Yet others of these new antidepressants have effects on dopamine. These medications may be effective for patients who have not responded to treatment with the older medications, and those that run particular risks from the side effects of the older medications. The newer antidepressants generally cost more than the older medications. One of these medications, fluoxetine (Prozac) has become the most widely prescribed antidepressant in the U.S.A.

One particularly interesting group of antidepressant medications is the monoamine oxidase inhibitors (MAOIs). This group has proven effective for certain treatment-resistant depressions, and is now considered the treatment of choice for certain somaticizing patients and some patients with panic disorders. These drugs were in use in the United States several decades ago, but severe reactions developed when patients took them and also ate certain foods containing the substance tyramine. In several cases, episodes of high blood pressure called hypertensive crises resulted. For many years these medications were largely abandoned in the U.S., although they continued to be used in Great Britain, where unusual effectiveness for the conditions noted above was found. Because of new discoveries about the safe use of these medications, they have come back into more common use in this country. However, fear of them continues to exist among some practitioners and pharmacists.
Lithium Carbonate

Although lithium is highly effective in treating and preventing bipolar affective disorder (also known as manic-depressive illness) it has limited usefulness among Indian people in that bipolar illness is thought not to occur among full blood Indian people. Bipolar illness is a condition which involves both major depressive episodes and periods that are the reverse of the depression, or mania. Manic episodes involve at least a week of unusually excited or irritable behavior, increased energy, decreased sleep, changes in appetite, feelings of having special powers or abilities, increased sexual appetites and a variety of other symptoms. For many people with this illness, lithium is both a treatment of acute manic symptoms and for prevention of the mood swings that lead to either mania or severe depression. However, since bipolar affective disorder is highly genetic in distribution (if one identical twin has bipolar disorder, the other has more than a 90% probability of also having the disorder) and it appears that this gene did not occur in Indian people before the arrival of the Europeans, bipolar disorder appears to be present mainly in Indian populations with a large amount of Northern European blood. In these populations, lithium can be useful; in other Indian groups, the use of lithium may be questionable.

Lithium is valuable in several other settings. It is a treatment for some patients with repeated violent outbursts and is a secondary treatment for certain medical problems, including bone marrow depression, certain thyroid conditions, and other disorders. The use of lithium in these general medical conditions is not highly significant, because there may be other, better medications for accomplishing medical treatment.

Lithium is a difficult drug to manage, requiring that blood levels be closely monitored, for there is a very small distance between the therapeutic and toxic levels. Lithium has significant side effects, yet it remains one of the most significant sources of hope for a normal life for patients with bipolar affective disorder.

Minor Tranquilizers

This is one of the more controversial groups of psychotropic medications in common use. In technical terms, this group of medications is called the benzodiazepines, and includes medications such as Valium, Librium, Dalmane, and others. These are among the most commonly prescribed medications in the country, but interestingly, relatively few are prescribed by psychiatrists. There is no doubt that, unlike the groups of medications discussed above, this group of medications has a clear potential for abuse and even physical addiction. The average patient taking doses in the therapeutic range runs relatively little risk of such addictions, but for those prone to drug abuse, able to obtain multiple simultaneous prescriptions of these medications, or using the minor tranquilizers in
conjunction with alcohol and other drugs, the benzodiazepines pose a major risk for addiction.

Alcohol and drug treatment staff frequently charge that these medications are "alcohol in pill form." This makes little sense from the pharmacological standpoint. This group of medications works in a very complex way in the brain, possibly through the action of Gamma Amino Butyric Acid (GABA) and possibly through the endorphins or other chemical transmitters in the brain. Interestingly, as has been shown with some of the newer minor tranquilizers, there is not necessarily a relationship between sedation and the ability to reduce certain types of anxiety, particularly anticipatory anxiety. The effects of alcohol and minor tranquilizers is in some ways similar in that there is that both have a general sedative effect, and some addictive-cross tolerance.

One of the beneficial uses for the minor tranquilizers is in managing alcohol withdrawal. Using these medications to taper gradually in an inpatient setting allows the alcoholic patient to withdraw from a severe and dangerous alcohol addiction. Their use in treating delirium tremens (D.T.s), which otherwise has a mortality of about 10%, is potentially life-saving. A practice still seen on Indian reservations, but which may be frank malpractice, is for physicians to prescribe benzodiazepines for alcohol withdrawal in an unsupervised, outpatient setting. In these highly inappropriate uses, the physician may give the patient a large bottle of medications, instructions on how to withdraw and a wish for good luck. Needless to say, patients who are already addicts will almost never use the medications as prescribed, and often use the medications as a "party" at IHS expense. Supporting rather than treating an addiction is against the law as well as being an unethical, but it is found with far too great frequency in physicians treating Indian patients.

Another negative consequence of the minor tranquilizers is the result of the metabolic pathways that some of the older medications in this group utilize in the body. The older drugs in this group often have active metabolites that have different properties than the parent compound. Perhaps the worst offender in this group is the medication Dalmane, which has been promoted as a sleeping medication. The primary active metabolite of Dalmane stays in the body for a very long time, exerting sedative effects. Because the levels of metabolite are increasing over time, the actual amount of active drug in the body may continue to build for several weeks until finally a "steady state" of excretion balanced with intake is achieved. For the elderly or those with organic mental syndromes this can easily produce a confused toxic state that may be mistaken for a variety of other conditions. Injectable Valium, for example, is so difficult to absorb into the bloodstream and excrete that the effects of even a single intramuscular injection can be detected on the electroencephalogram (EEG) for a month or more. Because of these and other difficulties, it is now taught that there is no reason to use intramuscular injections of many of the benzodiazepines.
Other negative consequences of the use of these medications include the occasional paradoxical effect in which the patient becomes violent and agitated as the dose of medications increase. There is some evidence that the use of the benzodiazepines interferes with one type of learning (anticipatory learning), and even some suggestions that long-term use produces significant personality changes. On the other hand, new studies suggest that these medications may help reduce agitation in acutely psychotic patients when used in conjunction with the neuroleptics.

Psychiatrists prescribe few of benzodiazepines for a variety of reasons. Psychiatrists understand sleep problems as usually being a symptom of another disorder rather than as a diagnosis. (Please see the section of this monograph on sleep disturbances.) In addition, in many cases, anxiety is considered by psychiatrists to be a symptom of other processes (such as panic disorder or a major depression) rather than a diagnosis. Psychiatrists who do find anxiety unrelated to another disorder may favor other forms of treatment, such as relaxation training or exercise. The experienced clinician in Indian country will always ask how much coffee the "anxious" person is drinking each day, and how the coffee is made. If the patient is drinking large amounts of coffee, is drinking strong boiled coffee, or is drinking coffee in the evening, caffeine must be suspected as a cause of the sleep problem.

A new generation of benzodiazepines (more expensive, of course) has specific anti-anxiety properties, and has improved metabolic properties that circumvent the problem of buildup of active metabolites. These drugs have shorter, finite half-lives of only hours in the body. Some of these medications, such as Xanax, Ativan, Serax, etc., are very rapidly absorbed and because they have such a clear and rapid effect, are suspected to be more habituating than the older medications.

There remain some clearly legitimate uses for the benzodiazepines. Following an acute catastrophe such as the death of a loved one or other major stress, these medications can be of clear benefit in helping a person through the initial stages of the episode. They may be helpful on a short-term basis in helping a phobic person making a major step in facing a phobic stimulus (such as the person who has a fear of flying and must get into the air just once) to start that phase of the desensitization program.

This group of drugs is controversial. It is clear that they are poorly and inappropriately prescribed in many cases. They give the uninformed clinician a too-simplistic way of satisfying patients' demands for some form of intervention when what should be done is to proceed further in the diagnostic process. In some cases the medications may be used in a harmful way. In other circumstances, there are useful and even vital reasons to use benzodiazepines. Clearly the answer to the appropriate use of these medications depends upon good reasoning and good training of clinicians.
Other Medications

There are a variety of other medications that have beneficial uses in mental health. Many of these new uses for medications provide some hope for conditions that were previously difficult to treat.

As an alternative to the use of benzodiazepines for situational anxiety, the beta adrenergic blockers (such as Inderal) have proven mildly beneficial. These medications prevent the patient from feeling many of the physical effects of anxiety, such as a racing heart beat. When there is no physical anxiety, the brain seems to follow the body's perceptions and to become relaxed. This group of medications is useful in situational anxiety, such as the anticipation of public speaking. Interestingly, this group is useful in treating the restlessness that is often a side effect of the neuroleptics. There are, of course, some potential problems with the beta blockers, such as the propensity of these medications to exacerbate or even produce depressive symptoms, and withdrawal from the beta blockers can cause heart rhythm problems. Interestingly, this group of medications does not appear to be effective in panic disorder.

Another group of medications that has seen increasing use in the treatment of major mental illness is the anticonvulsants. These medications have been found to be useful in several psychiatric conditions. Carbamazepine is useful in several conditions that were previously very difficult to treat, including periodic outbursts of violence and rapid cycling bipolar disorders which are resistant to lithium. There is increasing evidence of the effectiveness of several other anticonvulsants in particular psychiatric disorders, although these disorders are by no means common.

Medications such as clonidine have been found useful in treating several addictions, including addiction to tobacco, and even reserpine has occasional uses in the treatment of otherwise untreatable psychotic conditions.

Individual Psychotherapy

If any single therapeutic modality can be said to be the mainstay of mental health treatment, it is psychotherapy. The talking relationship between a therapist and client or patient is the best known tool in mental health. A great variety of approaches or schools of psychotherapy are in current use around this country and Europe.

There is wide diversity of opinion about the effectiveness and fundamental characteristics of psychotherapy. A decade ago, studies appeared to demonstrate that the process of psychotherapy depended not upon the learning and formal training of the therapist, but upon natural characteristics of the therapists which include genuineness, warmth, and empathy. The therapist's theoretical orientation appeared to make no discernable difference in the overall course of therapy. Indeed, studies from that time appeared to support the contention that formal training of the
therapist makes little or no difference in the outcome of therapy, and that untrained people with warmth, genuineness and empathy produced, overall, as good or better results as trained therapists. These findings were disconcerting to psychotherapists.

Fortunately for psychotherapists, the last decade has produced data which modify the conclusions of earlier psychotherapy outcome research. The behaviorists, whose approach to psychotherapy has been perhaps the most truly scientific of the psychotherapies, demonstrated that systematic desensitization, practiced in an exacting manner, is significantly more effective than nonspecific forms of therapy. This finding marked the turning point in research about the effectiveness of psychotherapy.

Since that time a number of other forms of psychotherapy have been demonstrated to be effective for specific problems. The remarkable effectiveness of interpersonal and cognitive psychotherapy for certain depressive conditions has provided therapists with a powerful tool; in some forms of depression, both interpersonal and cognitive therapy appear to be about twice as effective as general supportive psychotherapy. For certain severe forms of depression, the combination of medication and interpersonal or cognitive psychotherapy appears to be much more effective than either modality used alone.

The past decade has witnessed the application of particular forms of psychotherapy to other mental health problems. Few serious clinicians would still maintain that a particular form of school of therapy is effective for all problems in mental health. The state of the art requires a careful assessment of the patient and matching of the psychotherapeutic approach to the patient's problem. It is no longer reasonable to assert that any particular form of psychotherapy is like a general tonic that cures whatever ails the patient. However, one still finds some therapists who practice as if this were true. Neither is it reasonable, as has been proposed by some from the biological psychiatry movement of Washington University in St. Louis, to assert that psychotherapy is entirely ineffective and is a fraud perpetrated upon patients.

Much of the new psychotherapy outcome research has been made possible by the development of manuals which define therapist behaviors associated with specific "schools" of therapy. Standardizing videotaped ratings of therapists' actions with the manuals, it has been possible in a few cases to compare forms of therapy. These techniques were used to demonstrate the effectiveness of cognitive and interpersonal therapies.

A further development of psychotherapeutic technique has taken place in the last decade. Therapists in the tradition of Milton Ericson and Jay Haley have begun to understand the paradoxical effect of therapy in some cases. If a group of patients is approached with any specific technique, a certain percentage will respond as expected, but another group will do worse than expected. For this "paradoxical" group of patients, indirect forms of suggestion such as story telling are likely to be more effective. The use of these indirect techniques is by no means alien to
Indian elders and traditional healers, who have used stories and metaphors to help people with their problems for centuries. Coyote stories, for example, are used by many Indian cultures to help shape the behavior of children by indirect means.

The practical effect of the last decade's findings about psychotherapy is that the skilled therapist is likely to be a good interviewer, with a wide range of skills in helping the patient define and characterize problems and strengths. The skilled therapist may use techniques of cognitive, behavioral, psychodynamic, or interpersonal therapy, but may not be confined to any overall single approach to therapy and not limited to general, supportive techniques.

Psychotherapy for Indian people has received very little study. It is clear that some forms of psychotherapy are effective or ineffective depending upon the cultural background of the patient and the therapist. However, anyone who has spent time working with mental health programs on reservations is aware that certain forms of therapy seem to be very ineffective with Indian patients (such as confrontational therapies). Conversely, other forms of therapy which could be expected to be ineffective turn out to be surprisingly useful with Indian people (such as behavioral therapies). Furthermore, certain forms of psychotherapy, based upon traditional Indian techniques of communication and healing, appear to be highly effective with some Indian patients. There is clearly a need to develop a uniquely Indian psychotherapy literature.

Psychoanalytic and Psychodynamic Therapy

The psychoanalytic school of psychotherapy grew out of experimental approaches to hypnosis and therapy by Sigmund Freud and Joseph Breuer. Freud found through hypnosis that past events at critical times in a person's life, particularly in relation to significant people, determined the nature of problems in the present. He discovered that the unconscious mind acts upon these old, but persisting conflicts in habitual forms of symptoms and behavior patterns of thought and feeling. By realizing the relationship of past events to aspects of the present, particularly things that the unconscious mind is hiding, the patient gains "insight," and thereby real control over the symptoms.

The contributions of Freud and the psychoanalysts to mental health and to the world-view of the twentieth century has been substantial. Many concepts of psychological functioning in the language and thought of American and European culture come from psychoanalytic thought. Freud developed the concept of "transference" to explain the feelings that patients develop about therapists, based not upon real characteristics of the therapist, but upon the psychological evocation of past people and relationships in the person's life. Freud and other analysts developed a system of therapy based upon this transference, as when, for example, the patient falls in love with the therapist or else becomes inexplicably angry
with the therapist whom the patient barely knows. In true psychoanalysis, the therapist is a blank screen, giving few clues so that the patient can project his or her feelings onto the therapist in order that they may be explored and understood. These feelings in turn give clues to long-standing conflicts and other issues in relationships. Therapists also have transference-like feelings, called "counter-transference," that must be understood and worked with.

The psychoanalysts gave us many other important concepts. They developed a theory of the development of drives in the psyche, based upon particular developmental stages and resolution of conflicts in those stages. Problems and accomplishments in toilet training, for example, are thought to relate to issues of control and creativity in later life. Freud's daughter, Anna, was one of the great analysts whose contributions included detailed formulation of the development of children, and the use of defense mechanisms to avoid anxiety.

The analysts have contributed many of major ideas to the thinking in mental health. Theories of personality and of internal conflicts called "neuroses" were developed by the psychoanalysts. Symbolism and dream analysis are the result of analytic thought. Most recently, new and significant theories of personality development (called "ego psychology," self-psychology, and object relations theory) have been developed out of the psychoanalytic movement. These new theories have potentially significant implications concerning some of the most troublesome behavioral problems of patients with personality disorders.

Perhaps the most significant problems of psychoanalysis are related to the expense, time and effort involved in a full psychoanalysis. A full psychoanalysis may take between five and 10 years, and may require that the patient see the analyst for an hour each day, five days a week. Furthermore, analysts are highly and expensively trained. The cost-benefit ratio of psychoanalysis is not favorable. In addition, psychoanalysis was developed for people from middle and upper socioeconomic groups from U.S. and European cultural backgrounds. Little work was done with psychoanalysis of the poor. In spite of the long history of psychoanalysis, there is little evidence that it is effective when studied scientifically and psychoanalysts have often avoided scientific studies of the outcome of their interventions. Some believe that analysis may make patients worse, but without serious study, neither the risks nor the effectiveness of psychoanalytic techniques are proven. Some transcultural psychiatrists and psychologists also argue that psychoanalysis and psychodynamic psychotherapy are culture-specific therapies for Europeans, and have little place in working with Indians, Asians, or Africans.

As a result of the difficulties with pure psychoanalysis, the analysts developed "psychodynamic psychotherapy," a psychotherapy aimed at resolving much more specific problems in a more rapid and directed way than in pure psychoanalysis. Nevertheless, the course of psychodynamic psychotherapy is very long in comparison with other common forms of
therapy, and it is rare to find an analyst or a psychodynamic therapist who wishes to work with Indian people. Although an elegant and intellectually stimulating model of therapy, many of the unsubstantiated claims of the analysts to have a universal therapy have lead to a waning of the predominance of psychoanalytic thought in mental health movement.

Psychoanalytic thought has given rise to a great number of other schools and techniques of psychotherapy. Founders of many other schools of therapy were trained as psychoanalysts and developed these new approaches to therapy because of some of the limitations of psychoanalysis. Transactional analysis is often known as a "poor man's psychoanalysis." This form of therapy encourages people to consider interpersonal interactions between two people in three "ego states," that of parent, adult, and child. The theory holds that one person acting in a "parental" way will elicit specific behaviors in others reacting as a "child," even though both people are really adults. Although this school was elaborated to a high degree into many subcategories, its use is on the wane. Transactional analysis is now used by most therapists as a technique rather than as a "school" of therapy.

Other schools of therapy ranging from gestalt therapy to existential therapy arose from psychoanalytic thought and training. Even the popular (pop) psychology movements such as the "I'm OK..." movement can trace an evolutionary course to psychoanalytic thought.

Behavioral and Learning Therapies

A number of modern approaches to psychotherapy are based upon experimental findings about how stimuli from the environment lead to learned behavior.

Ivan Pavlov, a Russian, the father of these schools of therapy, discovered the process of "classical conditioning" by which a dog was fed in conjunction with the ringing of a bell, and the dog's production of saliva measured. Pavlov found that over time the food became unnecessary, and that only the bell was required to stimulate the production of saliva in the dog. This conditioned pairing of two stimuli and a response, even after the first stimulus has disappeared, has such clear implications for human learning and thought that it produced several generations of work on conditioned learning, and a wide variety of other research and therapies.

Following "classical conditioning" model of Pavlov, other complimentary models of conditioning were developed, such as instrumental conditioning and Hull’s learning theory. B.F. Skinner became well known even outside of psychology and psychiatry for his theories of "operant conditioning" and for his complex models for learning and behavior based on experimental findings in the laboratory. Theories of operant conditioning are sufficiently powerful that they have found their way into daily usage. Many modern concepts of managing employees in organizations come from the "operant conditioning" model. Issues such as
reward and recognition schedules in organizations owe their theoretical origins to Skinner and his followers.

Behavioral techniques in therapy are very effective when used correctly. Behavioral models for the "unlearning" of phobic symptoms produce the most effective techniques for overcoming simple phobic symptoms. Parents are taught behavioral techniques to modify the behavior of their children. Patients are encouraged to keep symptom records to measure the effectiveness of various treatment interventions. All of these techniques owe their place in therapy to the behaviorists. Because of their experimental and scientific orientation, behavioral therapists have some of the best documentation that their therapy works.

As with psychoanalysis, a large number of newer therapies owe their theoretical cores to the behaviorists. One new school, cognitive therapy, maintains that internal thoughts give rise to actions and feelings. In this school, the therapist and the patient develop new ways of thinking about events and relationships in order to counteract faulty internal models that lead to maladaptive thoughts and behaviors. For example, a depressed student may feel completely worthless because of a bad grade on a single examination. The therapist may help the student overcome the faulty thought that a single bad examination grade means that the student is entirely inept, and the thought that as a result the future is hopeless. The approach to changing the patient's thinking might be based upon setting up "experiments" by which the student proves to him- or herself that he or she is not incompetent.

A number of other therapeutic techniques owe their intellectual origins to the behavioral school. Biofeedback is a very powerful technique that uses information gained from electronic sensors attached to the body to teach the patient how to alter various physical functions. Biofeedback is useful in working with certain types of headaches, chronic pain, and certain forms of anxiety. Some of the current difficulties in the use of biofeedback are not in the reliability of the technology or the basic process, but in the misapplication of the techniques to incorrectly or improperly diagnosed conditions, or to use with conditions for which biofeedback is not an effective intervention.

The various relaxation techniques are related to biofeedback and hypnosis. These techniques can be taught reliably to most people and are effective in working with certain early forms of high blood pressure. Otherwise, the relaxation techniques are used primarily as an adjunct to other forms of therapy, such as systematic desensitization for phobias, or as a tool for interrupting situational anxiety, such as anxiety generated by work situations. Relaxation training and other stress-reduction techniques are certainly not cure-alls and may be counter-productive in paranoid or severely obsessive patients.

Although the behavioral and learning theory-based therapies are often strikingly effective, there are several disadvantages to their use. The purely behavioral therapies tend to pay little attention to the internal state
or feelings of the patient. They usually require a high level of motivation and activity on the part of the patient. They tend to not be intellectually satisfying to patients who intellectualize a great deal, even though they are effective. For these reasons, behavioral techniques tend to be unpopular with American Indian patients who hold strong cultural beliefs that their wills and intellects are the masters of their moods and behaviors.

Thus cognitive therapies and therapies such as “reality therapy” and rational emotive therapy tend to be more popular with Americans than purely behavioral therapies. It is this clinician’s opinion that many Indian people, at least in the Northern tribes, tend to be even more oriented toward this belief in will and toughness than the average American. As such, it might be expected that Indian people would not be inclined toward the behavioral therapies. However, several skilled behavioral therapists who work for the IHS have years of major success with these therapies, while other therapists who are perhaps less experienced report frequent rejection of behavioral techniques by Indian patients. Other therapists, including this author, have used cognitive approaches with Indian patients with what appear to be a much higher level of acceptance than the purely behavioral techniques.

Supportive and Client-Centered Psychotherapy

These two groups of therapies are associated more in their use in the field than in their ideological roots. Supportive psychotherapy evolved in the context of the psychoanalytic movement as a vehicle for caring for patients considered too ill or incapable of forming the relationships necessary for psychoanalytic or insight-oriented psychotherapy. Client-centered psychotherapy, in contrast, was developed by Carl Rogers, a psychologist, as something of a reaction to what he considered the "medical model" of mental health espoused by the behaviorists, the psychoanalysts, and the more neurological psychiatrists. In the field, these techniques tend to merge in practice.

The therapeutic techniques of supportive psychotherapy are not intended to produce change or "cure" in the patient. Supportive psychotherapy was developed in order to care for patients with schizophrenia or severe personality problems who could not otherwise be helped. In practice, the therapist spends time every week or every several days making as much contact with the patient as the patient needs. Time is spent trying to make the patient feel better about him- or herself and in providing gentle help and advice for the patient's daily life. This advice, it should be noted, is oriented toward survival issues for the patient, such as not yelling at the boss at work, or even teaching the patient how to take the bus or to apply for welfare. The therapist helps the patient return to a prior functional level after a severe illness, and helps the patient learn to tolerate difficult situations.
Client-centered or "Rogerian" therapy is based upon the relationship between the patient/client and the therapist. Unlike psychoanalytic psychotherapy, the aim is to have the patient experience the therapist as a genuine, accurately empathic person, who cares about the patient and reflects the patient back to him- or herself. In the form in which Rogerian therapy is used most frequently, therapy is based upon a number of concrete interviewing techniques that almost all trained therapists learn at one time or another (and are sometimes used to such excess that they become the source of humor for the public). Reflective statements such as "You feel angry" or summary reflective statements such as repeating the last few words of the client's last statements in the form of a question such as "...you felt unhappy when you couldn't go to the party?" are standard fare in this brand of therapy.

Taken together, these two forms of therapy are often used by beginning therapists and as a "fall-back" strategy by therapists who are in difficult and uncertain situations. Although ineffective for many conditions, these techniques are unlikely to offend patients and are easy to use when a sense of direction has been lost. It has been shown that patients do in fact respond and feel better in response to this approach to therapy. Studies demonstrate that patients likely to respond to the supportive and client-centered therapies include those who suffer from situational problems and normal grief. For these patients, ventilation about feelings and fantasy can be valuable. For chronic patients, in contrast, ventilation about feelings can cause outbursts of violence or psychotic decompensation, and is definitely not appropriate.

Of all the forms and schools of therapy in use in Indian mental health programs, these supportive forms of therapy are probably the most common. There are good and bad reasons for this. Among the appropriate reasons is the fact that there are an overwhelming number of patients with situational problems and grief on reservations. These supportive techniques may be the most appropriate to use with the average patient on the average reservation. In contrast to more "technical" forms of therapy, a high level of training may not be necessary to perform supportive or client-centered psychotherapy. However, some degree of clinical supervision is necessary to help inexperienced therapists avoid destructive or dangerous areas, such as getting psychotic patients to express their feelings.

The bad reasons for the popularity of these forms of therapy on reservations include their political safety. With most other forms of therapy, patients may become angry with their therapist as a normal part of therapy. This anger may be as a result of transference, having little to do with any reality of the therapist's behavior or personality. In the unique environment of practice in many IHS and tribal ambulatory health care settings, in which administrators or tribes may fire or punish therapists who make patients angry, supportive and client-centered psychotherapy is safest.
therapist is not required to do anything that might endanger his or her standing in the clinic or with the community.

Another bad reason for using only these two forms of therapy is that they are easy. The risk of feeling satisfied with a practice of only client-centered or supportive psychotherapy is that for many patients, other forms of psychotherapy may be more effective. The security of sticking with only these easy therapies may deprive patients of more effective interventions.

Nevertheless, supportive and client-centered psychotherapy is the mainstay of Indian mental health and it is appropriate that Indian programs insist upon a background in these two therapies for all mental health workers. Because of this, we have an obligation to support these forms of therapy with training and supervision. As with all forms of treatment, we must always be certain that these forms of therapy are appropriately chosen as the result of a good evaluation and diagnostic process, are matched to the problems of the patient, and are chosen out of a repertoire of possible approaches available to both the therapist and patient. We must also work to create a climate that is sufficiently secure that the therapist is not limited to these non-offensive therapies simply because they will not make anyone angry.

Interpersonal Therapies

Of the two proven effective psychotherapies for depression--interpersonal and cognitive therapy--interpersonal therapy is much less widely known or understood. Like cognitive psychotherapy, it is practiced in both formal and informal structures. The psychotherapy outcome research that demonstrated the differential effectiveness of interpersonal and cognitive psychotherapy over "supportive" psychotherapy techniques used highly structured, formal versions of these two therapies. Such formal versions are necessary in research settings so that a specific form of therapy can be replicated among different therapists, and to ensure that all the patients in a research study received very similar interventions. It seems probable that the majority of the practitioners of cognitive or interpersonal therapy in the field are less rigid than the formal, research versions of either of these therapies. However, it may be that as the field clinician diverges from the formal version of the therapy, it becomes less effective than the therapy upon which the outcome research was based.

The contamination of interpersonal therapy with "supportive" techniques is of concern. Interpersonal therapy has its roots in psychodynamic therapies of the same name. The theoretical roots of the techniques arise from the work of Adolph Meyer, Harry Stack Sullivan, and others. The basic underlying assumption of interpersonal therapy is that depression arises from difficulties in interactions among people, rather than from a primary source in the psyche. The ideas or deficient skills that the
person brings to social interactions create expectations and patterns of behavior which both create dysfunctional relationships and lead to depression. In research settings, interpersonal therapy is a highly structured, precise therapeutic technique. Perhaps even more than with cognitive psychotherapy, however, the therapist who has only passing familiarity with the formal techniques of interpersonal therapy may be tempted to believe that he or she is providing interpersonal therapy, while actually providing a less effective intervention.

In interpersonal therapy for depression, the therapist provides a diagnosis of depression and an explanation of depression as an illness. The therapist legitimizes patients' "sick role," allowing them to avoid blaming themselves for their difficulties. The therapist negotiates a treatment contract and may use medication to treat the depression.

In the course of therapy, the patient and therapist review the major problem areas in the patient's life. Together they attempt to determine if the problems are related to the patient's current depression, and which areas of dysfunction are related to specific interpersonal relationships in the patient's life. Past relationships are reviewed and any difficulties in these relationships are reviewed. The therapy focuses upon resolving interpersonal style difficulties that may produce unsatisfactory relationships and cause depression. Termination of the therapy follows standard psychotherapeutic techniques. The book by Klerman, Weissman, Rounsaville, and Chevron listed in the suggested readings is perhaps the best available work for becoming familiar with the various techniques and strategies of interpersonal therapy.

The use of interpersonal therapy in Indian country is untested, to the author's knowledge. In some cases, cultural factors may make it difficult to apply this therapy to Indian people. However, the levels of grief, interpersonal disputes, and role transitions, on Indian reservations suggest that this form of therapy may be highly effective in treating depression among Indian people. Therapists learning to use this form of therapy on reservations should report their findings in the Indian mental health literature if the results are as dramatic as one might expect.

Although interpersonal therapy holds great promise for application to depression among Indian people, it must also be remembered that this form of therapy, perhaps more than cognitive or behavioral therapies, deals with attitudes and behaviors strongly rooted in the patient's culture of origin. For example, grief and loss are regulated by cultures. Navajo grief and mourning practices suggest that long discussions of the death of another person may be unproductive because of fear that the "chindi" (spirit) of the person may be summoned, an undesirable event in the extreme. The therapist using interpersonal therapy techniques with Navajos would need to modify the therapy greatly to deal with death in a culturally appropriate way. Sensitive applications of interpersonal therapy in Indian cultures will probably require many modifications. The field of Indian mental health
awaits further investigations of this form of therapy and its documentation in the literature.

Psychotherapy for Psychosexual Disorders

The psychotherapeutic approach to psychosexual disorders is a highly specialized and complex field. A variety of problems are treated with these therapies, which are always used in conjunction with a team that includes medical specialists of various types. Admittedly the use of the psychotherapy for psychosexual disorders is rare in Indian country. However, as newly defined problems of a psychosexual nature begin to surface, attention to these modalities is increasing.

No one knows much about the prevalence of psychosexual disorders among Indian people. Not even the most basic information is known. Few studies have looked at questions of homosexuality among Indian people although clinical practice suggests that it exists in many Indian cultures. Neither has any study ever been performed that examines the prevalence of sexual dysfunction such as impotence in Indian men or orgasmic difficulties in Indian women. Only recently have we begun to be aware of the high incidence of sexual abuse among both males and females on some reservations.

Our lack of information about sexual issues among Indian people is quite understandable. Indian communities, which have long been the subject of biased publicity in the non-Indian world, are sensitive to the public airing of information about sexual issues of their people. From the author's experience, Indian communities in some parts of the country tend to be more tolerant of a range of sexual orientations and behaviors than current American society, although there are strong barriers against discussing these sexual issues. For promoting individual mental health of people with a range of sexual orientations, this tolerance of behaviors is admirable, for it allows for greater security and self-esteem among people with sexual orientations that differ from the norm. However, in the case of severe problems that harm or abuse others, this tolerance may prevent these people from coming to treatment early in life. Of great concern is the possible effect of the lack of knowledge of Indian sexual behavior and prohibitions against speaking about sexual issues in the context of AIDS and HIV infection. This illness could be come firmly established in Indian communities and kill many Indian people before its presence is known because of cultural prohibitions against discussing sexual issues.

It is important to consider the therapeutic modalities that are effective in working with various psychosexual disorders if only to offer a measure of hope to those who suffer from them. Particular forms of male sexual dysfunction are easily and highly effectively treated with modern techniques. Premature ejaculation is very effectively treated with behavioral and physiologic techniques. Inability of women to experience orgasm is also treated easily in many cases. Male impotence is somewhat
more difficult to treat, but if due to psychological rather than physiologic causes, it can often be treated effectively by a variety of techniques matched to the needs and wishes of the patient.

Sexual identity issues are often considered to be not disorders, but identity issues. Homosexuality is not listed as a disorder in the DSM III-R. Treatment aimed at changing sexual identity has never proven to be effective. Generally, therapy for homosexuals is aimed at helping the person to become comfortable with his or her sexual orientation and treating depression and interpersonal difficulties that may occur as in any other person. It is unclear what problems of adaptation and social stigmatization may exist for Indian homosexuals, although many therapists working in Indian communities have been trained to work with the specific problems of homosexuals in their non-Indian training programs.

Other psychosexual identity problems find unexpected sympathy and acceptance by many tribes. In some parts of the country, transsexualism (most often men who believe that they were born in the wrong body and wish to be women) is more common than might be initially thought, and have been present back into tribal history. An example of this role is the Lakota "winkte" man who was considered to have strong medicine powers. In some Indian cultures there is a traditional medicine role for these people, which may account for their more healthy cultural acceptance.

There are a variety of treatment alternatives for transsexualism, depending mainly upon the personality of the patient. In transsexuals with generally good adaptations to life, surgery for sexual change or "reassignment" is often considered appropriate. In the early operative series, however, patients with poor social adaptation and erratic work histories ran such a high risk of postoperative psychiatric complications that surgery for these patients is now being routinely refused because of the suicide risk. For this later group, supportive psychotherapy is used.

Of perhaps greatest concern are the people who are attracted to violent or harmful sexual practices. Rape appears to be frighteningly common on reservations, although it may not often be prosecuted. Rape is usually considered to be a primarily violent rather than a sexual crime. Rapists generally respond poorly to most forms of treatment. Of equal concern are the pedophiles who routinely and without any feelings of wrongness demonstrate a sexual preference for children. Not all child sexual abusers are pedophiles, and some may be amenable to various forms of treatment such as when child sexual abuse is carried out in the context of a delirium. Pedophiles, in contrast, are a very difficult group to treat, even with the new biofeedback and behavioral/cognitive techniques that seem to hold at least some promise.

Several reservations have developed sophisticated programs to work with sexual abusers. However, increasing pessimism seems to dominate the feelings of IHS staff about treating Indian sexual abusers, as it does in non-Indian programs. Some of the problems encountered involve getting the legal system to obtain the guilty plea or the conviction needed.
in order to assure treatment compliance. In addition, the treatment outcomes for working with pedophiles is not impressive, although certainly not completely impossible as many practitioners believe.

Much of the therapy for sexual dysfunction is so specialized that it should not be attempted by untrained therapists. Although a case could be made for increased awareness of therapy for psychosexual difficulties, it would probably be inappropriate for the IHS and tribal programs to create a major focus on the treatment of these disorders. In the first place, therapeutic modalities are difficult and require substantial training. With absolutely no information about the epidemiology of psychosexual difficulties on reservations, it would be difficult to justify the expenditure of resources on such treatment. In addition, the issues of confidentiality and community opinion about such treatment programs may be a major problem. It probably makes the most sense to train therapists working with Indian programs to recognize psychosexual disturbances and to maintain a good network of contract referral sources in the private sector, or in conjunction with other state or federal treatment programs.

Traditional Indian Individual Psychotherapies

From the author's experience, it is clear that in some parts of the country there have been and still may be practitioners of traditional Indian healing techniques that are valuable and effective. Currently, many of the practitioners of Indian therapies are very old, in their seventies and eighties, and are often members of particular medicine societies. In some Indian communities these Indian therapies and healing techniques have been passed on to younger people. In other tribes, however, the traditional healing techniques have not been passed to the next generation for a variety of reasons, and they will die with their practitioners. In several of these healing traditions, the fundamental beliefs, particularly about development and parenting, resemble psychoanalytic beliefs, although the intervention techniques are very different. In other cases, the beliefs resemble personality theory based on interpersonal therapies, except that the intervention techniques involve story telling and suggestive techniques more commonly than non-Indian versions of these approaches. In some cases, strong interpersonal therapeutic results are obtained through social institutions, such as in the case of Sioux "teasing cousins" as a desensitization technique for narcissistic issues of youth. In fact, during a conversation with the late Herb Fowler, a Sioux psychoanalyst, he once remarked to the author on the remarkable congruence of psychoanalytic thought and traditional medicine beliefs of the Sioux groups of which he was aware. Similar observations are often heard from Indian therapists with formal training in "Western" therapies, as well as training as traditional healers. In one case, a mental health worker was required to give up his work in an IHS program in order to be the keeper of the sacred objects of his tribe. He said he found his new duties to be very much in accord with
his duties and training in mental health. Indeed, it is interesting that often very traditional Indian people are the staunchest supporters of some of the more structured psychotherapies and even pharmacotherapy.

The IHS has not succeeded well in its efforts to incorporate Indian medicine techniques and beliefs into its daily operations, although at one time the IHS supported a school for Navajo healers. Perhaps one reason for this lack of consistent success in incorporating healers into IHS programs in the northern U.S. is that many of the traditional healers generally do not wish to be associated with government programs or with "Anglo" medicine. Although legitimate healers certainly do become affiliated with IHS programs, often non-Indians will identify a person as a healer who is not trained in one of the Indian medicine traditions. Non-Indians are often unable to tell the brilliant traditional Indian healer from a person who the local Indian community considers to be a fraud. The reliance of non-Indians upon sometimes less than the most respected healers may work to diminish the credibility of the non-Indian therapists in Indian communities. Because Indian people may belong to a variety of religious backgrounds and may sometimes be unsympathetic to traditional Indian medicine, the non-Indian therapist is well advised to be cautious in promoting Indian traditional healing, in spite of its validity and therapeutic potential. Indian therapists rarely have these difficulties.

Because many of the traditional therapies have developed over a long period of time in response to the mental health needs of the people, it is reasonable to guess that at least as great a variety of traditional Indian psychotherapies existed at one time as the number of other psychotherapies which exist in America today. As with non-Indian psychotherapies, some are likely to be effective and some ineffective. For the reasons discussed above, it may be best that IHS not make a formal effort to incorporate traditional psychotherapies into its treatment programs. However, because of the value of some of the traditional therapeutic modalities, it is essential that they be passed on to younger people, if possible.

**Group Psychotherapies**

One of the myths of therapy for Indian people is that group psychotherapy is ineffective. It was long taught that for whatever reason Indian people became so uncomfortable in groups that group psychotherapy should not be attempted. Indian mental health professionals and paraprofessionals have disproven this old belief. One of the new movements in Indian mental health is the use of group psychotherapies to provide effective help for Indian patients when there are too few therapists to provide individual therapy for the large number of patients on a particular reservation or with a particular problem. Group psychotherapy is a promising tool for further development of the Indian mental health system.
Many Indian cultures have a long tradition of groups for social and religious activities involving techniques which can be regarded as group psychotherapy if one is so inclined. The ways in which clans and elders in some Indian communities pass on information about how to live and act correctly might be regarded as group therapy. Similarly, the use of the sweat lodge in some Indian cultures accomplishes many of the same goals as group psychotherapy.

In the tradition of mental health in Europe and America, the roots of group psychotherapy lie in the era of moral treatment, in which lectures were used to instruct patients in the proper way to live. In more modern times, Joseph Hersey Pratt, an internist, led groups of tuberculosis patients to lend mutual support to each other. Pratt began his groups as "classes" in 1907. He found that testimonials of patients who had responded to treatment in front of the group of patients provided hope and helped people to feel better. This technique is thought to have been the foundation of the use of testimonials in Alcoholics Anonymous in later years.

This technique was applied to mental patients by L. Cody Marsh in 1919. Following the success of this health education, lecturer-like model of group psychotherapy, the technique became increasingly refined. In the 1970s, group psychotherapy spread rapidly in non-Indian mental health practice, and by the end of the decade had divided into a variety of "schools" much like the schools of individual psychotherapy. As with individual psychotherapy, the techniques of group psychotherapy have come to range from the extremely conservative psychoanalytic groups to the (often ridiculed) group exercises of fire-walking and nude encounters that seem to abound in California.

In most forms of group psychotherapy, the therapist is a facilitator of the group interaction and provides structure for the group. He or she helps to draw out shy members and keeps others from getting carried away in their self-revelations or attacks upon other group members. In some forms of group psychotherapy, the therapist provides different ways of looking at patients' dilemmas and other experiences.

Because group therapy in mental health services in Indian mental health is so new and not used widely, it would seem premature to enumerate the "Western" group therapies used on reservations in this monograph. Rather, it is worth noting that there are several therapy techniques that seem to be effective in the hands of a few professionals practicing on reservations today. The traditional Indian group interactions that serve as group therapy techniques call for further exploration and documentation in the Indian mental health literature.

Single Issue Groups

Probably the most common form of group therapy on reservations is the support group organized around a single issue or topic. In Montana, one mental health practitioner has developed a very effective group for
phobic Indian patients as a part of a broad program for panic disorder, anxiety, and phobias. This program is so successful that Indian people from several nearby states have visited the program to become familiar with the therapeutic techniques and take them home. Canadian Indian people have also visited this program with similar aims, and non-Indian patients from surrounding communities have applied for membership in the group because of its reputation for effectiveness.

The format of the Montana group is mixed, in that lectures on various aspects of the illness are given, testimonials are used, and the group works together to support members having hard times. The group provides a valuable social network of mutual help and protection even outside of formal meetings, a tendency that is often discouraged in non-Indian therapy techniques. This Montana group provides one model of effective group therapy with Indian people.

Other groups based on single issues are being very successfully and creatively organized, usually by Indian therapists, in other parts of the country as well. Perhaps the most common group focus in the Pacific Northwest, for example, is for adult victims of sexual abuse. Other good examples of issue-specific groups around the country include groups for Indian Viet Nam veterans and groups for patients with specific medical illnesses, such as groups for diabetics. Of course, perhaps the most common and successful supportive single issue group in Indian country is Alcoholics Anonymous, which has become a mainstay of Indian alcoholism treatment programs.

Single-issue groups appear to hold great promise for future efforts in Indian mental health. Because only one or two therapists are required for a group of eight to 10 people, this is a very cost-effective form of therapy. In addition, single-issue groups may be more effective than individual psychotherapy for certain problems. For patients who have difficulty with authority, these groups can provide help and support without making the patient fight the therapist to the point that therapy becomes impossible. Patients with unusual beliefs can check their perceptions of reality with a group of patients with similar problems, and people can practice new interpersonal skills in the safe and protected environment of the group.

**Traditional Values Groups**

One of the most interesting group therapy technologies for Indian people was organized by an Indian psychologist on one of the reservations in the West. This technique utilized tribal elders to teach traditional values and Indian medicine to people having a variety of mental health problems. People invited to participate in this group therapy were identified as being at risk for suicide and other major problems by the mental health program using standard diagnostic and evaluation techniques. In the group, people might sit around tables beading or making things as they were taught by the elders. Both the psychologist and a traditional healer worked in a
conversational manner to help the patients resolve problems in a very non-directive manner, such as by telling stories. Using this technique, the suicide attempt rate on the reservation was reduced from 33 in one year to none in the next year.

A variety of similar techniques of group therapy have begun to be used in Indian mental health programs around the country. There is no doubt that these therapeutic techniques will play a major part in Indian mental health programs in the future. It should be pointed out, however, that the people who created these effective Indian program of group psychotherapy are highly skilled people using a combination of very structured mental health skills and traditional healing techniques. These combined programs of Indian and non-Indian group therapy have been effective when run mostly by Indian mental health professionals with solid backgrounds in both "Western" and traditional Indian healing.

Self Help Groups

Unlike other forms of group therapy, self-help groups do not utilize a therapist to supply structure and direction. Rather, the group is organized and directed by its members, sometimes with the help of someone who has a mental health background. Members of the group generate movement and support, usually according to a set of known rules or principles unique to the group. Self-help groups of many sorts are in operation in both Indian and non-Indian communities. Adult sexual abuse victims, families of severely mentally ill patients, and veterans are among the groups that meet on various reservations as self-help groups.

Other Psychotherapies

Many other possibly effective forms of therapy exist, ranging from the subtle and powerful to those which may be ineffective or even ridiculous. One of the most colorful of these ineffective therapies is based upon the belief that "orgone" radiation, produced by coal dust, could be concentrated in a box insulated with steel wool or rock wool and used to cure patients placed in the box. Not directly related, but similarly unusual are therapies which seek to release stored psychic energy from the muscles and joints through "bioenergetics" or even Rolfing, a massage therapy technique.

At the same level of general professional unacceptability as Rolfing or orgone generators are therapies that use megavitamins and dietary control of mental state by avoiding refined sugars, etc. While these therapeutic modalities are relatively harmless, they may prevent unsuspecting patients from seeking therapies with proven effectiveness. More dangerous are therapies in which the patient is held down until he or she is "bonded," which have been declared to be unethical by the American Psychiatric Association.
The existence of various supposed therapies ranging from the highly effective to the frankly harmful and bizarre, illustrates the need for strong ethical guidelines to protect patients from unethical or harmful therapeutic interventions. In addition, the presence of inadequately trained therapists or therapists who misuse the therapeutic relationship for self-serving ends testifies to the need for explicit ethical guidelines, as well as a strong system of clinical and program supervision. For this reason, most mental health systems have a clinical director or supervisory body to police the psychotherapy in a mental health organization. In general, people from one of the mental health disciplines are needed to evaluate therapeutic practices, rather than a general medical practitioner or an administrator.

**Family and Couples Therapy**

Although family and couples therapy are the mainstay of therapeutic practice in non-Indian mental health programs, these forms of therapy are not nearly as common and not reportedly as successful in Indian communities. Reasons for this are not entirely clear.

Family and couples therapy is a specialized form of therapy that is focused on communications and relationships in the family or couple. A wide variety of techniques are used, depending upon the particular form of family therapy the therapist believes in using. The "schools" of family therapy include systems orientation, interpersonal, psychodynamic, behavioral or psychoeducational approaches.

Family therapy as used in the general American mental health community accomplishes a number of specialized tasks. One form of specialized family therapy is a technique used in the long term treatment of anorexia nervosa. This form of family therapy teaches the family to stop trying to make the anorexic eat and places responsibility on the anorexic using "paradoxical" techniques. Family therapy is used in the treatment of some forms of sexual abuse and is one of the few interventions that both protects the child and preserves the family. Obviously, sexual abuse cases appropriate to this form of intervention must be chosen with extreme care.

Family therapy is routinely used to help the family cope with difficult or taxing situations, such as the loss of a family member, serious mental or physical illness, or the problems of adolescents. The techniques of family therapy often involve altering stereotyped family roles. Frequently, family members develop mental health problems because of pathological family dynamics. For example, a child may develop symptoms as a result of a hostile relationship between the parents. The child may find out that the parents stop fighting when the child becomes ill. Thus, the child the develops more and more problems in order to prevent fights, and the other children, realizing this phenomenon, may do all they can to make the "identified patient" child continue to be ill. The family therapist must provide the parents with a behavioral alternative to fighting in order to cure the child.
Another example of family therapy is used for families with children suffering from various conduct problems. Parents who are too controlling or inconsistent in limit-setting often inadvertently produce conduct problems in their children. In these cases the behavior problems can be alleviated by changing parenting techniques (for example, gradually easing unrealistic limits on the child). If the parents do not have the ability to use normal parenting skills, such as limit-setting, the therapist may supply these parenting skills him- or herself. One variation of this theme is the teaching of parenting skills, which involves a combination of health education and family therapy skills. However, purely educational skills may not be effective for many major family problems. Another form of family therapy, a psychoeducational model aimed at reducing "expressed emotionality" in certain families, has been shown to reduce relapses in major illnesses such as schizophrenia.

Couples therapy utilizes many of the same skills as family therapy. Communication between the members of the couple is usually the focus of the therapy. In addition, techniques such as behavioral contracting are routinely used. With this technique each member of the couple agrees "I will do X if you do Y." As in family therapy, either one or several therapists together may provide couples therapy. Usually, the more effective forms of couples therapy utilize two therapists, who then work out typical conflicts of the couple, "modeling" appropriate conflict resolution while each represents one of the members of the couple. Other techniques include setting rules for conflicts, teaching assertiveness skills, symptom prescription, scheduling techniques, and a variety of others.

Both couples and family therapy appear to be highly effective for problems of families and children on reservations. However, it has often proven to be extraordinarily difficult to get all the family or both members of the couple to come in to the therapy sessions. On a number of reservations, it is particularly difficult to get adult men into couples or family therapy. It appears clear that values in some Indian families may prevent family or couples therapy in many cases. Whether the difficulties in getting men into family and couples therapy are really a matter of traditional Indian values, or if it is the same problem with male roles as the rest of America remains to be determined. Another reason to develop Indian mental health literature is for the therapists who have discovered effective techniques of family and couples therapy with Indian people in some cultures to describe these techniques. This could be a substantial advance in Indian mental health technology.

Network Therapy and Related Techniques

Unlike family and couples therapies, network therapy appears to be highly successful whenever it is used on reservations. Unfortunately, network therapy is such a major effort that it can be used only in cases severe enough to merit the time and expense.
Network therapy is useful in precisely the kind of complex social networks that exist among the agencies and extended families on reservations. It is particularly useful for the most troubled multi-problem families. Network therapy works by assembling the entire extended family, advocates who represent each member of the family, and representatives from all the agencies involved in the care of the family members. In this process, which has been likened to the grand opera of psychotherapy, everyone defines the problems of the family in terms that are satisfactory to all family members and all agencies. Using specialized therapeutic techniques, the therapist brings from the group a plan to solve the problems of the family, or at least to manage the system-wide crises precipitated by the family. Often this is the only possible way to gain control of the troubled family that has learned to get its needs met by setting agencies against each other.

The only difficulties with this highly effective form of intervention (which may be the only possible intervention in some cases), is the enormous expense of tying up a large number of professionals for hours in order to accomplish the therapy. Few therapists currently working in Indian country are trained in this technique.

Psychotherapeutic Techniques for Children

The psychotherapy of children is a critical area of concern within the Indian mental health system. If the epidemiologic estimates of the high levels of mental health problems among Indian children are accurate, the modalities of therapy available to deal with these problems must be of very great concern to the IHS and to all programs working with Indian health issues. If we are to have any impact upon the mental health problems of Indian children, we must be concerned with the range of therapeutic techniques available to deal with the children's mental health problems.

As is the case in adult mental health, therapeutic techniques used with children must be based upon an accurate and adequate evaluation. The difficulty with evaluations of children is that they are often much more difficult and exhaustive than evaluations of adults. Because of the increased complexity of evaluating children and adolescents in the context of multiple simultaneous developmental lines, complex family and social and family networks, and in the face of mental, physical, neurological, or sensory disabilities, a team of health professionals is often needed to perform a comprehensive evaluation of a child's mental health problems.

Child therapy could be impossibly complex if approached with a goal of absolute comprehensiveness. However, the best child therapists use a combination of somewhat abbreviated screening techniques and history-gathering from family, teachers, and the child. Experienced child therapists seem to have a special instinct for children's problems and an ability to arrive rapidly at a formulation of the major problems in order to intervene as effectively and quickly as possible. Because of the high level
of complexity of this field, it may be that there is much more "art" and less science to child therapy than in adult or geriatric therapy.

Child therapists often use several techniques of therapy simultaneously. A child with a severe emotional disorder may require play therapy or other interventions at the same time as another therapist provides family therapy. The child may be simultaneously taking medications for a major mental disorder or epilepsy as he or she undergoes other forms of treatment. Several professionals may need to work together, such as mental health professionals, social workers, special education teachers, physical or occupational therapists, and pediatricians. When the therapy becomes this complex, the services of a case manager (see below) are required to insure adequate continuity of care.

However, particularly with younger children, the therapist cannot rely exclusively upon direct individual verbal psychotherapy. Children communicate their internal states through play and behavior much more effectively than through words. Abstract concepts that would be clear to adults may be beyond the understanding of the child until 11 or 12 years of age, according to Piaget. Because of this difficulty in using words, therapy with children must be accomplished by a variety of less direct means, such as play therapy, family therapy, recreational therapy, art therapy, and the relationship with the therapist. The therapy of children, like the diagnosis of children's problems, requires more art on the part of the therapist than the technical skills of adult therapy. Some of the major therapeutic modalities for children are listed below.

The Therapeutic Relationship in Child Therapy

The relationship between the child or adolescent and the therapist is perhaps even more critical than the relationship between the adult patient and the therapist. For children, one of the most commonly encountered problems is difficulty in a relationship with a parent or other caretaker which the relationship with the therapist helps to heal. For example, a mentally ill parent may at one time reward a child and at other times punish him or her for exactly the same behavior. At other times the child may repeatedly be put into "double bind" situations in which he or she is given two choices by the caretaker, both of which will result in punishment. In still other cases, the parent or caretaker may set limits with the child, but not follow through with the consequences when the child tests those limits. All of these habitual actions and many other interactive patterns can contribute to emotional difficulties in the children.

The role of skilled child therapists in these cases is to provide a relationship which in some measure balances out inconsistent or harmful interactions. Generally the child therapist's ability to sustain such a helpful relationship is the result of long training and supervision, in addition to his or her natural skills in this area.
In addition to the behavioral consistency of the child therapist, emotional factors are equally important in working with children. The ability of the therapist to show positive feelings toward the child in spite of the child’s behavior is communicated clearly and directly to the child. The ability of the therapist to display "non-conditional positive regard" for the child, genuineness, and accurate empathy is important.

The development of these relationship skills is the result of the personality of the therapist, skilled supervision for several years in training, and enough experience to become comfortable with children who are acting in strange and disconcerting ways.

Untrained and unsupervised staff working with children and adolescents may make major mistakes in the therapeutic relationship with children as a result of good intentions and their own unresolved developmental issues. With adolescents in particular, untrained therapists may identify with the patient too strongly and begin to share in the chain of damaging relationships that the child or adolescent has experienced. The inexperienced therapist who has unresolved adolescent developmental issues may identify so strongly with the child or adolescent that he or she begins to fight the goals of the treatment system. For example, it is all too frequent to find untrained therapists or "counselors" keeping the child from meeting with the regular therapist, or colluding with the child to sabotage the treatment plans made by the treatment team.

In other instances, untrained or unsupervised therapists may identify so strongly with the child that they begin to enter the child’s pathological world, becoming "immeshed" in the pathological family dynamics or other harmful interactions in the child’s network. In the worst cases, therapists may even take a child home with them, out of a treatment facility where the child or adolescent is placed. As a supervisor of mental health programs, the author has encountered this problem with disheartening regularity in programs that use unsupervised staff in the child and adolescent treatment programs. These situations are very difficult for a supervisor to repair. In these situations, further emotional damage to the child or adolescent may occur, as may professional damage to the therapist.

In the worst case, the greatest therapeutic and administrative nightmare possible, a pedophile may find his or her way into a role as a therapist. It is thought that pedophilia may be an extreme version of identification with the child or adolescent. It is a disaster when a pedophile, with sexual preferences for children, finds his or her way as a therapist into a treatment or recreational program, using the position of a trusted adult to take advantage of children.

For these reasons, the selection, training, and supervision of therapists and others who work with children is critical. One of the major defects in some Indian health programs is the lack of a chain of therapeutic supervision. There is great room for error and unethical practice in mental health programs for Indian children and adolescents.
Play Therapy

For several reasons it is not possible to use verbal or talking therapies with children as extensively as with adults. According to Piaget, who studied their intellectual and cognitive development, children may not be able to understand abstract concepts like those used in many forms of adult therapy until they are at least in their early teens. In addition, children do not generally use words as their primary means of understanding the world, relying more upon physical interactions with the environment, global cause and effect relationships, and symbolic representations of events.

Children who come from understimulated environments may also not have had sufficient practice with language, so that their ability to talk about experiences lags behind their ability to understand the experiences in non-verbal ways. At particular stages of normal development, and in the case of certain children who have had bad experiences with adults, children may have a problem trusting the relatively unknown adult therapist, or perhaps any adult at all. Talking about experiences may require the highest level of trust of any form of communication available to the child. As a result of all of these factors, verbal therapy and verbal evaluation techniques for children may be ineffective.

A variety of non-verbal techniques have been developed to overcome the difficulty of verbal therapy and evaluation. Play therapy is perhaps the best known and most consistently effective of these non-verbal techniques.

In play therapy, the therapist and the child interact around play in a way that explores significant issues for the child. Using toys, the therapist is able to explore the child’s feelings, thoughts, and actions. In the same session that a particular issue is being explored, the therapist can use play to suggest, indirectly, solutions to the child’s problem, new ways of coping with the problem, or to accomplish other therapeutic goals. In play therapy, the processes of evaluation and therapy may be closely connected.

The play therapist must have at his or her disposal a wide range of toys that are appropriate to the age and developmental level of the child. Using the toys, a very wide range of issues can be evaluated and interventions performed. Certain toys can be used to assess a child’s intellectual and neurological skills. The child’s general emotional adjustment, mood tone, and reactions can be grossly measured. For example, the therapist can play catch with the child. In doing so, the therapists observes neurological differentiation of left and right hands, the reaction to frustration of bad throws, the reaction to aggression from the ball being thrown too hard, and a variety of other factors.

Play therapy can become very complex. One common instrument of play therapy is the use of dolls representing various family members in an open doll house. The therapist and child can construct a wide variety of situations, evaluating how bad things can happen, exploring fantasy about how things could happen, and using the dolls to suggest to the child new
ways of coping with difficult situations. A specialized form of therapy and evaluation uses anatomically correct dolls to evaluate and perform therapy for children who have been victims of sexual abuse. Many toys are marketed as special tools for play therapy. However, many play therapists prefer to use toys that are sold in regular stores. In either case it is important that play therapists have an adequate budget for the purchase of a range of toys that are effective with different age ranges and for exploring different issues. However, the adaptive play therapist can use almost anything that the environment presents as a tool in play therapy. For example, for children too agitated to play in the clinic setting, the author routinely walks with the child outside, using sticks, dirt clods, discarded plastic bottles and other litter found around the clinic in order to perform play therapy "on the move." Children who come from very impoverished backgrounds may sometimes be intimidated by expensive fancy toys, so sticks and dirt clods may be better toys in some cases.

The Jungian therapists have pioneered the use of a variation of play therapy using sand trays. The sand tray is a large flat tray containing sand and, sometimes, water, small toys or figures, and whatever else can be brought into service. This technique has advantages over other forms of play therapy in that it offers much more flexibility to construct the world in the sand tray, populate it with characters, and create situations and actions. The only disadvantages is that sand trays are untidy and should really be used in a room with a floor drain (and certainly with no carpeting). Some of this disadvantage can be overcome by using cornmeal instead of sand, since cornmeal can be cleaned up with a vacuum cleaner. However, cornmeal is more expensive than sand, and in the author's opinion, is not as much fun.

Play therapy is certainly the mainstay of therapy with children. However, unless the health care system understands the value and purposes of play therapy, it is often difficult to get the resources and support needed to perform these therapies. Toys always look odd on a federal purchase order, as do requests for modification of a room to include drains for washing down the room. In a health care setting, therapists and children who make big messes are not popular, and they are rarely given the same budgetary consideration as the need for a new cardiac defibrillator.

Art Therapy

The advantages and disadvantages of play therapy are complimented nicely by art therapy. Just as gross motor skills of the child can be tested easily in play therapy, fine motor skills and coordination can be evaluated using clay or drawings instruments. Even though play therapy is useful in bringing out themes and issues that the child would not talk about, art therapy can bring out even more deeply hidden issues. The way that a child draws a person, for example, can show not only the child's intellectual development, but can reveal things about the child's
self-concept, views of others, and a number of issues that would be much more difficult to access in other ways. Drawings are well enough standardized that they can be read with a fair degree of accuracy by comparison with those of other children.

However, drawings are more difficult to use in an interactive way than play therapy. In some cases, the therapist and the child may draw interactively upon the same piece of paper. This technique can be powerful in working directly with barely conscious symbolic issues. All in all, however, the relatively static form of paper can never be as dynamic as other forms of play.

The use of modeling clay or other plastic media has many of the advantages of paper of allowing the child to creatively structure the objects of play, and also allows the child and therapist to play interactively with the clay models. The main disadvantage to clay is that it is more difficult than in drawing for the child to produce something with which he or she is satisfied, and so is probably best used with older children. (This would perhaps be less of a problem if childrens' toys were not made in such intricate detail at this point in history.) Modeling clay is fairly expensive, and reasonable substitutes can be made with cornstarch, cornmeal, water and food coloring. It is good to have clays or doughs of several colors, although these cannot be re-used well when mixed together as inevitably happens.

Recreational and Outdoor Therapy

For older children and adolescents, recreational therapy and outdoor therapy provide good opportunities for working out a variety of problems. Both forms of therapy provide opportunities for the older child and adolescent to confront issues of getting along with other people, to confront and master new and unfamiliar situations, and to work out relationships with adults.

Recreational therapy is practiced in a variety of ways. Competitive sports teach some lessons about the competitive world of adulthood and about working with groups of people as team members. However, unless great care is taken, competitive sports tend to diminish the self-esteem of children and adolescents who are uncoordinated, who are not good at getting into the "in crowd," or who have difficulties with aggression. Used incorrectly or insensitively, competitive sports may do serious damage to the children who are most in need of help.

Non-competitive sports and outdoor programs offer advantages for therapeutic purposes over the competitive sports for adolescents. Rather than giving the advantage in competition to the adolescents who need it the least, the adolescent learns valuable lessons about mastering him- or herself, and about competition against nature. One program, Outward Bound, was well known in its day for assisting adolescents with personality-based or conduct problems.
However, data supporting the positive outcomes of these forms of therapy is lacking. Used improperly, these programs can markedly exacerbate problems of adolescents who need the most help. Used well these programs are good ways of strengthening self-esteem of adolescents, and helping work through issues of interpersonal relationships and personality issues of the adolescent years. There is no doubt that these experiences can promote the mental health of adolescents.

However, it should in no way be thought that these forms of therapy are central forms of therapy for seriously ill adolescents. These programs are non-specific in their effects, and have no documented efficacy in preventing any specific negative outcomes such as suicide or death in traffic accidents. A more specific treatment plan is needed for children and adolescents with known risk factors for negative outcomes and known illnesses. However, as treatment proceeds, there is a good place for these therapeutic modalities in an overall treatment program.

Other Therapies for Children and Adolescents

Many forms of therapy have been used for the treatment of children and adolescents. Family therapy is a standard and critical therapeutic modality that is usually used in combination with individual therapy.

With adolescents, many of the forms of therapy used with adults are also valuable. Although the therapeutic issues of adolescents are usually different from the therapeutic issues of adults and the relationships between therapists and adolescents are somewhat different, the processes of therapy are generally similar.

It is, frankly, a matter of grave concern that in the IHS there are so few mental health services offered for children and adolescents. Special training is required for mastery of the therapeutic techniques for children and adolescents. Unfortunately, in most Indian programs, therapists are expected to work with children and adolescents with little or no training or supervision in doing so. When administrators require work with children from these general therapists, few refuse to see the children in spite of their lack of training, because of the merit pay system which punishes such refusals and the knowledge that if they do not provide the services no one will. This is an area in which administrators and clinical supervisors can demonstrate leadership in setting standards for hiring child therapists, arranging special training for therapists in child therapy, and in arranging for trained clinical supervisors.

Summary

In this chapter, we have reviewed a range of types of treatment for mental health problems of adults, children and adolescents. The purpose of this review is to familiarize the non-practitioner with broadly defined types of therapy, both biological and psychological in use on reservations today.
Many therapies hold promise for effective use in treating major mental health problems, but even those which have been well studied in non-Indians have not been studied in Indians. As a result, the applicability of all non-Indian therapies to Indian populations should be considered carefully by clinicians, and should be the subject of future research.