II

MENTAL HEALTH PROBLEMS AFFECTING INDIAN PEOPLE

Introduction

In order to be able to realistically prioritize mental health services for American Indian people and to design and operate programs designed to address those problems, an understanding of the mental health problems themselves is essential. This understanding should include symptoms, the basic course of the illness or the problem, what is known about the cause of the illness, and what treatment techniques and prevention strategies are available to meet the problem.

In Indian mental health, the problems are of a diverse nature, with different degrees of severity, causes, courses, and effective treatments. This diversity is reflected in the complexity in the tasks and duties of the Indian mental health programs themselves. Understanding these diverse problems need not be daunting, however, if one uses a system of some sort for categorizing and grouping them. Diagnostic systems in psychiatry and the other mental health disciplines currently represent the best-available means to grasp the overall scope of the mental health problems of Indian people.

Modern diagnostic systems attempt to be "phenomenological;" that is, they are based upon observations of the characteristics of mental illnesses in nature, as opposed to classifications based upon supposed cause. The diagnostic system in widest use in the United States is the Third Diagnostic and Statistical Manual, Revised (DSM III-R) of the American Psychiatric Association. The DSM III-R represents the consensus of professionals from several mental health disciplines about the diagnostic categories and criteria for these diagnoses among the American people. Although it is not perfect nor always perfectly phenomenological, it is currently the best available diagnostic system for use with the American population as a whole.

This chapter generally follows the diagnostic criteria and the terminology of the DSM III-R. There are several risks to the application of the DSM III-R to American Indian populations, however. Mental illnesses and mental health problems may in many ways among differing cultures and ethnic groups. Disorders that have a genetic cause differ among different races in their prevalence, severity, prognosis, symptoms, and best-available treatments. Disorders that have psychological roots differ on the basis of a host of factors, including the customs of the culture, the linguistic world of the person suffering from the illness, and even (perhaps)

according to the child-rearing practices in the person's culture of origin. Mental illnesses arising from organic causes vary according to the different physical illnesses affecting the different populations. Social causes of mental health problems vary widely, and may include beliefs of the culture, ways in which the members of a family interact, and a staggering array of cultural factors that influence the mental health of the individual. It should not be expected that the diagnostic system derived from one culture can be in all ways applicable to members of another culture.

In considering the diagnosis of mental illness among American Indians, it is doubtful that the DSM III-R is in all ways applicable. Unfortunately, however, so little work has been done on the diagnosis and classification of mental illnesses among American Indians that the DSM III-R may still be the best guide to the mental illnesses of Indian people. There is an acute need for research in Indian mental health designed to test the validity of DSM III-R diagnostic groupings when applied to Indian populations. Workers in the field, including the author, have applied the DSM III-R and its predecessor (the DSM III) to the mental illnesses of Indian people for many years, and it is at least useful, if not completely accurate, in describing the patterns of illness seen in practice. The discussions in this chapter are based upon this clinical experience. Where diagnostic groupings seem to differ significantly from the DSM III-R in practice or according to the available research, I have tried to note the observed differences.

In spite of reasonable circumspection in the application of non-Indian diagnostic systems to Indian populations, one should avoid the notion that diagnosis of mental illness is itself suspect. Diagnostic systems are currently the key to research on the epidemiology, causes, and treatments for mental illness. The patient who is not linked to a diagnostic grouping is deprived of the benefits of decades of research in mental health that connect the diagnosis of an illness to it's effective treatment. Without a diagnosis of some sort, the application of treatment techniques is at best haphazard and at worst potentially harmful. Although the value of diagnosis in mental health is often self-evident to those outside the mental health field, one still occasionally encounters a few practitioners who believe that mental health diagnosis is evil or bad in that it "labels" patients. These practitioners believe that ill effects of the stigma attached to a mental health diagnostic label outweigh the potential benefits of effective treatment. This belief was common in training programs in the early 1970s and can still be found in a few graduate schools. Fortunately, increasingly rigorous quality assurance efforts by third party payers for mental health services may effectively cause the demise of this belief system in the next few years.

Just as it is wise to be circumspect in the application of all DSM III-R diagnoses to Indians, one should be aware that within any diagnostic system some diagnoses are better than others. The extent to which all individuals with a particular mental illness share the same symptoms, course, and outcome is related to the validity of the diagnosis. The extent

to which several diagnosticians armed with the same diagnostic criteria and seeing the same patient can agree whether the patient has the diagnosis is called the reliability of the diagnosis. In order for a diagnosis to be "good" it must have both validity and reliability. Some of the diagnoses in the DSM III-R are better than others, even without applying them to Indian populations. It is to be hoped that better diagnostic systems will be developed for both Indians and non-Indians in the next decade.

This chapter discusses the diagnostic groupings of mental health problems found in working with Indian people. Each of the diagnostic groups contains a description of the mental health problem and its symptoms. Where possible, treatments for the different conditions are discussed, as are the known causes and the impact upon the individual and the population. This material builds in the following chapters into an understanding of the patterns of mental illness in Indian communities and the treatment systems for these illnesses.

It is important to have an idea of the cause and natural course of the disorders one is attempting to control. The first tool in understanding the cause and course of an illness is performed by finding a number of people with similar symptoms and studying them to see if they develop similar courses and similar secondary health problems. If these people do develop similar secondary symptoms, they are assumed to have the same illness or problem. If a name is applied to this condition, such as "schizophrenia," "hypertension," or "diabetes," it is called a *diagnosis* or *diagnostic category*. Other patients with the same symptoms are "diagnosed" as having the same illness.

In order for the health planner to determine the usefulness of a diagnostic category, he or she must realize that not all diagnostic groupings are equally valid as measured by the ability to predict course and outcome of the illness, particularly when these diagnoses are applied by clinicians in the field. If the planner asks several questions about the diagnostic category, the value of the specific diagnostic category can be determined. For example, is the diagnostic category a "phenomenological" classification based upon real observations of nature, or is the diagnostic classification based upon an assumption about the cause of the disorder? Syphilis is an example of a "good" diagnosis. The symptoms of the early phases of the illness are similar in most people, the course is similar in most people, and there are common groups of secondary symptoms, such as deterioration of certain parts of the central nervous system. The symptoms of the illness cause clinicians to order serum tests to confirm the diagnosis. The diagnosis of syphilis is based upon observation of symptoms and confirmed with a laboratory test.

A poor diagnostic category results when people are clustered not by symptoms and course, but by a presumed cause. For example, several centuries ago in Europe diseases were categorized as humoral imbalance (such as black bile or yellow bile). Too much of one or the other of the humors was thought to be the cause of all disease. All symptom groups

were explained as an imbalance of humors and one of four treatments applied (such as bleeding the person to let out the humor). Needless to say, this diagnostic system did not help to find the real causes of disease nor its treatment. In mental health, an example of a poor diagnostic group is adult victims of sexual abuse; the people who experienced this traumatic event have markedly different courses and severity of symptoms. Some victims suffer from depression, panic disorder, phobias or a host of other problems. Other poor diagnoses include "neurosis." If the diagnostic system is good, most of the people with the same diagnosis should have the same symptoms upon which independent clinicians can agree. All people with the diagnosis should share the same expectations about the course of the disorder and its outcome. The same treatment should work with most if not all of the patients with the diagnosis. In mental health, some diagnostic categories, such as organic mental syndrome, are very "good" diagnostic groups that reflect these similarities. Other groups, particularly the personality disorders, have relatively poor prognostic ability and inter-rater reliability.

Disorders of Adulthood

Based upon the author's work with many of the tribes of the West and upon two decades of studying Indian mental health literature, the following are disorders that are common and problematic for Indian people in several parts of the United States. In general they are similar to the disorders that affect non-Indians in this country. With a few notable exceptions, the disorders present similar symptoms among Indians and non-Indians alike. The differences in these disorders between the Indian and non-Indian populations arise from the differences in frequency in the population and from the likely outcomes of the problems.

Bereavement, Situational and Adjustment Disorders

The most common group of disorders in any population are problems that do not merit a diagnosis of major mental illness. This group of problems may involve difficulties with some aspect of the environment, such as a marriage, divorce, family issues, cultural adjustment issues, or issues related to job, school, or to other situations in life. This is a group of issues that could affect anyone. Symptoms may include anxiety, feelings of distress, concentration difficulties, and a variety of other symptoms.

Course: These disorders tend to resolve easily if the situational stressors resolve or are removed. If the stressful situation is not resolved, the person must either find a way to cope with the situational stressor or developmental issue, or else face some risk that the bad feelings will become chronic. Without successful resolution of the problem some long-term maladaptive problem may result. For Indian people, these problems are the same in general nature to those that occur with the

non-Indian population, but may arise from unique social or environmental conditions. For some Indian communities, situational stressors tend to occur in groups or to be unusually severe. In some places, a high rate of traffic accidents causes grief in large families that last for several years when a continuing series of losses of relatives causes the normal course of grief to be restarted time after time. On some reservations, unemployment rates over 80% of the population cause intense and ongoing stressors for the community, while in other areas, frank racism by non-Indian neighbors produces stressors that are difficult to understand by those who have not experienced these conditions. In yet other communities, the breakdown of traditional family and cultural roles places stress upon individuals in the community. Except for young males whose suffering from adjustment disorders increases risk and death, this group of disorders poses relatively little risk of death, but does produce functional impairment.

Treatment: Generally, research has shown that therapist characteristics of genuineness, warmth, and empathy make far more difference in the effectiveness of therapy for situational disorders than the specific techniques used by the therapist. It is the consensus of the professions that the treatment of choice for this group of problems is supportive psychotherapy. However, certain specialized therapeutic techniques have been shown to be of value in situations. Part of the treatment depends upon the staff performing adequate mental status examination on patients who present with environmental and situational complaints. When the professional misses the diagnosis of a major mental illness (assumes that the patient has a situational problem and fails to perform a diagnostic examination), the results can be harmful or can even lead to the death of some patients. A diagnostic examination of the patient is critical in the treatment of both situational and major mental disorders. Likewise, specific forms of therapy for situational stressors, such as family therapy, couples therapy, inter-personal therapy, or others may be particularly useful in major mental disorders as well.

Schizophrenia-Spectrum Disorders

This group of disorders consists of a number of severe conditions that are, fortunately, rare in Indian communities. There are several illnesses in this category ranging from acute psychotic episodes which resolve in several days to the most severe condition, schizophrenia, which may have life-long symptoms. For most of these disorders, symptoms usually appear in the late teens, twenties, or early to mid-thirties, depending upon the sub-type. Symptoms consist of hallucinations, usually auditory (usually voices that sound like they are outside the person's head saying bad things about the person), and bizarre ideas called delusions. Depending upon the type of delusion, symptoms may consist of ideas that people are reading or stealing the person's thoughts, that there is a conspiracy to "get" the person,

that the person's thoughts are leaving his or her head to go to items in the environment, or other similar ideas that do not respond to reason or evidence. People suffering from these problems develop unusual ways of thinking and acting that make them difficult to tolerate in their communities or families. This constellation of symptoms is defined as "psychotic." In addition to these present or "positive" symptoms, this group of disorders also has absent or "negative" symptoms such as a loss of initiative, difficulty with abstract thinking, absence of motivation, loss of creativity, etc. Schizophrenia is at least in part genetic, and occurs in every population in the world.

Schizophrenia, the most severe of these conditions, appears to occur in Indian populations with a much less than one percent prevalence. Nevertheless, when schizophrenics are found on reservations they are very expensive to care for, particularly because of the chronicity of their conditions. Schizophrenia appears to occur in pockets in Indian communities (although research is needed to determine this), and so works a greater hardship on some communities than on others. Little is known about the unique nature of schizophrenia among Indian people, including whether or not the presentation and course of the illness are different for Indians in comparison to non-Indians. The course of schizophrenia in the non-Indian population is controversial (with some authors suggesting a high rate of improvement over 20 to 30 years and others suggesting a low percentage of improvement, if any at all). Nothing is specifically known about the expected course of schizophrenia among Indians. However, if we take an "average" of the literature and apply it to Indian populations, we should expect to find three groups of outcomes for those who initially meet the diagnostic criteria for schizophrenia: those who recover completely over the decades, those who have some residual symptoms but who can function in the world, and those who go on to a life-long deteriorating course.

Course: The most severe group, about one third of the patients who meet the criteria for schizophrenia, go on to develop a progressive downhill course with a step-wise worsening of symptoms over the years. This deteriorating course may be the result of a biological process or from social factors resulting from institutionalized living conditions. The form of deterioration may be persistence of positive or negative symptoms, or an inability to survive socially in the community. Another third of patients who develop psychotic symptoms recover with treatment and do not deteriorate. The final third of patients who develop psychotic symptoms have future psychotic episodes, may have some long term problems, but do not continue to deteriorate after the episodes. Chronic schizophrenics run a high risk of early death due to suicide, accidents, violence, and death resulting from infections and cancer.

Treatment: Treatment differs in different phases of the illness. Medications of the "neuroleptic" group, such as Thorazine or Haldol have proven quite effective for stopping hallucinations, delusions, and agitation. Patients with a sudden onset of psychotic symptoms related to the

schizophrenia spectrum illnesses almost always require hospitalization and use of these medications. However, in some communities, schizophrenics have been successfully treated for acute episodes in motels, general hospitals, and their homes. Talking therapies are almost entirely ineffective at this stage of a psychotic episode. In the longer term, treatment of the disorders consists of prevention of future psychotic episodes, which bring on further deterioration. In addition, long-term treatment of schizophrenics is based on trying to keep them functioning in their home communities and on reducing stress.

The past decade has seen a revolution in the technology available to accomplish these treatment goals. Revolutionary technology includes the use of case managers, partial hospitalization, day hospitals, adult foster homes, supervised living situation, psychosocial rehabilitation, and skills of daily living training. Medications are often needed on a chronic basis. In addition, psychoeducational programs which reduce "expressed emotionality" in family communications have been demonstrated to reduce relapse in schizophrenia, as have family advocacy groups such as the Alliance for the Mentally Ill. Consumer advocacy groups also hold promise for improving the treatment of schizophrenia. The new interventions for schizophrenia are specialized and may require a great deal of staff training and special programs. On rural reservations with a few schizophrenics scattered over large geographic areas, practical applications of these new technologies may be difficult or impossible within existing economic limitations. The use of traveling case managers, regional hospitals, and regional psychosocial rehabilitation programs may be one solution to returning Indian people suffering from schizophrenia to productive roles in their home communities.

Affective Disorders

This is perhaps the most significant group of mental health disorders, and one of the most significant overall health problems facing Indian people today. Affective disorders are known to be different among Indians in comparison with non-Indians. For some types of depression, the news is good for Indian people. The most strongly genetically transmitted affective disorder, bipolar affective disorder (previously called manic-depressive illness), appears to be very rare if it exists at all in full-blood Indian people. Bipolar affective disorder has both periods of extreme excitement that last for many days, and low, suicidally depressed periods. Bipolar disorder appears to be transmitted through non-Indian gene pools, although some Indian groups with early historical contact with English and French trappers and Scandinavian immigrants do have substantial numbers of people suffering from this illness.

It appears that Indian people do suffer very seriously from "major depressive episodes," in addition to a number of specific forms of lesser depression. Major depressive episodes, from which people with European

backgrounds suffer as well, have clear patterns of genetic transmission and are clearly related to changes of the chemistry of the brain as well as changes in thinking patterns and patterns of social interaction. The symptoms of major depression consist of sleep changes, early and multiple awakenings, appetite changes and weight change (often rapid and massive), loss of concentration, feelings of guilt, hopelessness, worthlessness, and thoughts of death. Things that were enjoyable for the person become uninteresting. Episodes last between two weeks and years, and may be the most significant cause of suicide among Indians and non-Indians. As many as one in six non-Indians suffering from depression will attempt suicide. These major depressive episodes are very treatable; if untreated, a person with a major depressive episode runs a three- to five-fold risk of death within the year in comparison to people who are not suffering from this disorder. There are now laboratory blood tests for these disorders, but they do not have perfect reliability.

Different forms of depression, particularly major depressive episodes, are now thought to be a major contributor to the development of alcoholism among at least a percentage of alcoholics. It has also been found in recent studies that patients suffering from psychiatric disorders in combination with alcoholism do not respond well to treatment in standard alcoholism programs. That they do not fare well in treatment for their psychiatric disorders alone has long been observed in mental health settings. Patients with these "dual diagnoses" present a challenge for the development of joint treatment programs; if successful, these programs may have a major impact upon improving the treatment failure rates reported for many alcohol treatment programs. The poor outcomes reported for some Indian alcoholism treatment programs may reflect a large number of "dually diagnosed" patients suffering from depression whose lack of response to treatment obscures the statistics for treatment outcome by those with simple alcoholism.

<u>Course</u>: As noted, people with a major depressive episode run a high risk of death from suicide, accidents, heart problems, infections, and cancer. Most major depressive episodes resolve on their own over a year if the patient survives. However, exposure of the patient to the risks from untreated or inadequately treated depression is far greater than the health risks from cigarette smoking for the same period of time, for example. To put this problem into a socio-economic perspective, some forms of depression among Indians appear to run a long term course over many years or even decades. The loss of productivity and the intense personal misery for those who suffer from the different forms of depression are substantial, as is the economic impact of these conditions. However, because several forms of depression appear to be somewhat unique to Indian people, and little is known about the risks of these forms of depression, their natural course, or their eventual outcome may be different from the more usual types of major depressive episodes.

Treatment: Treatment for major depressive episodes has been intensely researched. The single most effective treatment for major depressive episodes is the group of medications known as "antidepressants." If used properly, this group of medications has a rate of effectiveness that is two-and one half times that of "counseling" or supportive psychotherapy. Some studies indicate that several specialized forms of therapy, particularly cognitive, resocialization, and interpersonal therapies, offer results only slightly less effective than medications if used alone. The combination of effective treatment of major depressive episodes such as combining cognitive psychotherapy with medications is likely to be the most effective treatment for depression. Other forms of depression respond to other specialized forms of therapy, although little work has been done to determine the efficacy of the specialized therapies for the unique forms of depression outside of the major depressive episodes. Little research has been attempted to determine which forms of therapy may be the most effective for Indian people.

Panic Disorder and Related Problems

Panic disorder and complications related to it represent a very interesting collection of problems from the perspective of the health care delivery system for Indian people. Panic disorder has been unrecognized and not understood until relatively recently. Only in the decade of the 1980s has an understanding of panic disorder brought about a virtual revolution in the thinking about anxiety-related problems and their treatment.

Panic attacks are the first phase of this illness. They appear among non-Indians from the late teens to the mid-30s. Among Indian people, it appears that the onset may occur even later in life than in the non-Indian population. The onset of panic disorders appears to be an almost purely biological event, unrelated to the basic psychological health of the patient. Panic disorder is known to run in families, to be associated with certain tissue types in selected cases, and to be associated with cardiac problems in about one-sixth of the patients suffering from it.

The panic attack itself is an episode of the most intense fear and apprehension possible. It lasts five to twenty minutes on the average and is accompanied by difficulty breathing, a feeling that the heart is beating hard and fast, dizziness, intense perspiration, numbness of the lips and fingertips, light-headedness, and an overwhelming feeling that something terrible is about to happen. Men experiencing a panic attack usually fear that they are having a "heart attack," while women fear that they are losing control, "going crazy," or are about to die.

After a number of panic attacks, a general state of anxiety begins to set in between episodes. The person begins to be apprehensive all of the time. If the panic attacks are sufficiently frequent, the person begins to avoid whatever activity they were pursuing at the time of the attack. For example, persons who were driving a car at the time they experienced a

panic attack become apprehensive about driving cars again. The building fear and apprehension lead to a pattern of avoidant behavior called "agoraphobia," or "fear of the market place." This may become so debilitating that the person may be unable to travel by car or plane, ride elevators, or go shopping even for groceries. In the most severe cases, persons may be unable to leave their house at all. We have found cases of Indian people living in remote rural areas who have not left their house for over a decade. Others are convinced early in their illness that they are suffering from severe heart problems. They come to emergency rooms during and after panic attacks and are given expensive tests or intensive care unit hospitalizations at over $700 per day. When the doctors (not recognizing panic disorder) find that the patient does not have heart problems, he or she is often discharged with the label or at least the suspicion of hypochondriasis. (Interestingly, the *New England Journal of Medicine* reports that 40% of patients with panic disorder have mitral valve prolapse on echocardiogram.)

Course: As noted above, this is a highly debilitating illness because of its natural progression. Unfortunately, it often tends to strike intelligent, talented people, depriving their communities of their skills. Also unfortunately, the majority of non-psychiatric physicians still do not recognize this illness and do not know how to treat it. Without adequate treatment, the patient suffers without relief. Many patients tend to begin to try to treat the anxiety by drinking, which only makes the panic attacks worse. There is reason to believe that panic disorders represent a significant and treatable fraction of the alcoholic population in Indian country. Other patients become isolated and embittered at the medical community that has failed to treat their illness and has labeled them as hypochondriacs.

Treatment: Several forms of treatment for panic attacks have been shown to be effective. Certain of the tricyclic antidepressants have been shown to be effective in preventing the panic attacks, but this group of medications does little or nothing to reduce the generalized anxiety between attacks. The monoamineoxidase inhibitors have been shown to both prevent panic attacks and reduce the generalized anxiety between attacks, and are now considered to be the first line treatment of choice for this disorder by psychiatrists. Recently, several groups have reported a cognitive therapy treatment for panic disorder that appears to be as effective as medications.

Treatment for the anxiety is probably best accomplished through the use of physical activity, cognitive therapy and relaxation training, or similar techniques. Some physicians prescribe minor tranquilizers of the benzodiazepine group for generalized anxiety, but this is definitely problematic for some patients, who may tend to become dependent on these medications. Treatment for the phobias comes from facing the feared situations in a controlled way through the use of behavioral techniques, cognitive therapy, group support, and a variety of other techniques. New,

special techniques for treatment of the phobic portion of this disorder have been developed for Indian people by Ms. Catherine Eder of Popular, Montana; techniques which have proven markedly effective.

Anxiety Disorders

Recently the diagnostic category of generalized anxiety disorder has come into disrepute. The majority of anxiety cases encountered in a clinical setting are related to panic disorder, major depressive episodes, or several other specific disorders. The diagnosis of generalized anxiety disorder, however, is still frequently used by practitioners who have not kept up with the literature, and who do not bother to fully evaluate their patients for other causes of anxiety. There are however, reputable practitioners who believe that generalized anxiety disorder exists after the other causes for anxiety have been eliminated in the diagnostic evaluation. Psychiatrists prescribe minor tranquilizers very infrequently, although the use of these medications by non-psychiatrists continue to make medications such as Xanax, Valium, and Librium among the most frequently prescribed medications in the nation. The frequent abuse of these medications when inadequately monitored or when given to alcoholic patients suggests that other forms of treatment for generalized anxiety disorder, such as relaxation training, meditation, exercise, hypnosis, and similar techniques, should be considered.

Course: Situational anxiety resolves with the resolution of the situation or the patient's learning new mechanisms for coping with the stressful situation. Other kinds of anxiety are resolved when the stressful situation goes away. Still other kinds of anxiety are resolved with resolution of the underlying problem, whether the problem is environmental, medical (such as hyperthyroidism, electrolyte problems, pheochromocytomas, etc.), or results from major mental illness. In some cases it may be that true generalized anxiety continues on a chronic course for much of a person's life unless effective therapy is provided.

Organic Mental Disorders

This group of disorders is one of the most problematic to deal with. The course may be either acute or chronic, depending upon the cause. The symptoms are impairment of judgment, orientation, memory, affect, reasoning, and a variety of other functions. Organic mental disorders may be marked by psychotic symptoms (i.e., hallucinatory and delusional), affective problems (mood), memory and orientation problems, or other types of difficulties. If the course is acute, organic mental syndromes represent an immediately life-threatening condition, requiring that skilled and specialized diagnostic skills to be used quickly and effectively to save the patient's life. Presenting as chronic problems, patients with organic mental disorders are often written off as "senile" by general medical

providers or are presumed to have Alzheimer's disease, which is a form of organic mental syndrome with a poor course and no known treatment at the present time. However, many recent articles reveal that more than half of the supposedly "senile" people are misdiagnosed and, in fact, have treatable conditions. There are over 300 medical conditions known to cause organic mental disorders, including congenital, infectious, toxic/metabolic, endocrine, neoplastic, vascular, autoimmune, and other causes.

Course: The course of this group of disorders depends entirely upon the underlying cause. On an acute basis, the skill of both the clinician mental health staff and physicians makes the difference as to whether the patient survives and recovers or not. The acute diagnosis and management of organic mental conditions is a specific skill that is fairly easily taught, but is currently not widely known by IHS and tribal staff in the field. For chronic organic mental disorders, the diagnostic skills required to isolate the underlying causes are no less critical than those required for the acute condition. With older patients, the skills required are often practiced by geriatrics specialists or gerontological psychiatrists.

Treatment: Because treatment of these conditions depends upon acute diagnosis of the treatment of the medical condition causing the disorder, the skills of a team are required. All mental health staff must be able to recognize organic mental disorders through the use of a structured mental status examination. When mental health staff identify a patient with such a disorder, the local physician must be brought into the case quickly and definitively. The use of a psychiatrist, an internist, or neurologist with behavioral sciences skills must then be utilized, either by referral to a large hospital, or by telephone consultation.

Substance Abuse Disorders

These disorders include a heterogeneous group of problems. Although alcoholism is most commonly thought of as the most significant of the substance abuse and dependence problems of Indian people, there are many other drugs and chemicals that are used and abused on reservations, and programs, even for alcohol treatment, may be inadequate and ineffective. In many parts of the West, inhalants such as gasoline, paint solvents, and other volatile compounds are abused by people from childhood to adulthood. The abuse of these solvents causes severe problems for the users, including damage to brain and liver tissue, and an increased risk of cancer. A pilot narcotics abuse program on one of the reservations in the West has found far more chronic narcotics abusers than even the program's designers had imagined, and has been overwhelmed with previously unsuspected narcotic-addicted patients. Most of the narcotics abuse found by this program was abuse of prescription narcotics, and there was a strong underground network for the sale of prescriptions on the streets.

Clinical experience demonstrates that a wide variety of drugs are abused by Indian people in the West. Drugs such as "angel dust" (Phencyclidine), amphetamines, sedative hypnotics, and so on are all found on reservations at different times. At present, almost no treatment is available for these non-alcohol substance abusers, and their problems are rarely recognized. The group of abused substances other than alcohol represents a major health problem of Indian people that there are almost no available resources to address.

One problem in the Indian alcoholism treatment system is the lack of competent detoxification programs for all reservations. Good detoxification requires that detoxification match the condition of the patient, from medical withdrawal using electrolyte management and benzodiazepine medication, to social withdrawal for patients with less serious physical habituation. Patients without adequate medical supervision and care throughout the detoxification process run a major risk of death or brain damage. However, throughout the nation, political differences have long separated alcoholism treatment programs from medical and mental health treatment providers. It is hoped that both systems of treatment could be made more effective through increased cooperation between these programs. The insistence on the use of non-medical, "social" detoxification programs on some reservations may be causing needless death and disability.

Course: The course of substance disorders depends upon a number of factors, from the drugs that are being abused to individual factors of the patient and the patient's social environment. The course of solvent abuse is often very severe, possibly resulting in permanent damage or death. The course of other types of substance abuse is dependent upon the unique characteristics of the abused substance and the patient. It appears that age may bear upon the long-term outcome of substance abuse, if only from the perspective that habits are easier to break if caught early in the course, and that the physical damage to the person is minimized if detected early.

Treatment: The acute treatment of the intoxication and withdrawal from these abused substances must be handled by specialized techniques in both emergency and inpatient settings. The long-term treatment for habituation to these substances is generally unknown for Indian people. An example of this is the treatment of inhalant abuse. There is no known long-term treatment that has been shown to be effective for treating inhalant abuse among Indian people. Other technologies that have been shown to be effective in particular settings are virtually unknown to the majority of treatment programs in Indian country. The literature on the outcome of Indian alcoholism treatment programs cannot demonstrate that the programs studied produce any better outcome than if the person had received no treatment at all. These findings contrast strongly with the enormous amounts of money spent on Indian alcoholism treatment programs, and highlight the need for serious research on new treatments

for alcoholism and other forms of substance abuse among Indians. A clear priority for research and program development must be substance abuse among young people. Currently, the technology needed to address this task remains largely unknown. There is a need for outcome studies of Indian people receiving treatment in both Indian and non-Indian programs.

Somatoform, Psychosomatic, and Somatopsychic Disorders

This group of disorders represents one of the most economically interesting groups of mental disorders for the IHS and tribes. These disorders represent a great drain upon financial and human resources of Indian nations. Patients with these disorders are heavy users of medical services which are often ineffective in working with them. By bringing mental health treatment into the medical clinic setting there may be substantial cost savings in the treatment of these disorders. By becoming more sophisticated in our interventions for these problems, Indian health care programs could potentially save large sums of money in our direct and contract health care programs.

Somatization disorder is a serious disorder in which patients begin by seeing themselves as "sickly" for most of their life. Patients with this disorder go on to develop a series of illnesses, including unexplained nausea and vomiting, conversion symptoms such as difficulty walking, temporary deafness and blindness, the loss of sensation or function, gynecological symptoms, arthritis, back pain, and other specific problems. Patients with this disorder tend to be subjected to multiple exploratory surgeries, including laparotomies. Their surgeries tend to cluster in the form of laparotomy, thyroidectomy, hysterectomy, laminectomy, and appendectomy procedures. Not only do they use up substantial funding, but they run risks to their lives and ability to function as a result of these serial surgical procedures. People with this disorder tend to frustrate health providers with the need to perform complex medical evaluations which repeatedly yield no medical findings.

Some specific disorders in this group are problematic in the general American population, but appear to be less common among Indian people. While psychogenic pain disorder is certainly present in Indian populations, it appears to be less common among Indians than in non-Indian groups. Psychogenic pain disorder (pain from psychological rather than physical causes) appears to be related to depression in many cases, unlike somatization disorder, it responds to tricyclic antidepressants. A whole technology exists for the treatment of these patients. This same technology has been found to be very helpful for patients with chronic pain from other organic causes, particularly diabetic neuropathy which afflicts many Indian people.

Psychosomatic and somatopsychic disorders span the gap between primarily physical and primarily psychological disorders. On one end of the spectrum are disorders of a primarily medical nature whose

course and severity have been demonstrated to be related to mental state. Disorders which affect the immune system are linked to the person's psychological state. For example, it has been demonstrated that depressed people suffer from cancer and infections more often than non-depressed people. The course of illnesses such as tuberculosis has long been known to be influenced by mood and mental state. Other disorders such as asthma and psoriasis have a known (though obscure) link to mental state. At the other end of the spectrum are disorders that result from psychological disorders with physical manifestations. For example, hyperventilation and intercostal muscle spasms result from anxiety.

A technology to deal with these problems has resulted from the consultation/liaison psychiatry movement. The use of mental health workers on medical/surgical wards has been shown to significantly reduce post-operative hospital stays and to reduce post-operative complications on orthopedic and cardiovascular units, for example. The possibility of effective detection and treatment of psychophysiological and somatopsychic disorders promises significant financial savings for the IHS and tribal programs.

Course: The most severe of these disorders from a psychiatric perspective is somatization disorder. It is difficult to treat at best, and the most that can be hoped is that the patient's episodes of illness can be controlled to the point that surgery can be kept to a minimum. Other disorders in this group are less severe, and in the case of the lesser disorders in the category, the effects may be temporary and circumscribed.

Treatment: The treatment for these conditions is quite varied. The treatment for somatization disorder is a specialized form of case management that requires following the patient through the medical system to make certain that medical evaluations for new symptoms are reasonable yet conservative. (The case manager helps the health care team avoid the surgeon's knife wherever possible.) Treatment for chronic pain, whether as a result of psychogenic pain disorder or pain from more clear-cut medical disorders, is accomplished with a series of medications starting with tricyclic antidepressants and extending in some cases to anticonvulsants or neuroleptics. The treatment protocol for chronic pain can be carried out by the general physician with specific training in this area. More difficult cases require the use of inpatient hospitalization and behavioral techniques, biofeedback, and a host of other specialized treatment methods. If the IHS had at least one such facility capable of treating chronic pain and illness behaviors in the country, a great deal of money could be saved and suffering alleviated. One of the reservation hospitals that currently has a low average daily patient census could be converted to treat this group of disorders to the great benefit to the tribes, IHS, and patients and their families.

Personality Disorders

Personality disorders clearly exist in Indian communities but their definition is controversial, particularly when applied to people outside of the mainstream American culture. Personality disorders represent life-long patterns of maladaptive behavior. For many years it has been thought that personality disorders result strictly from problems in the person's development in childhood. However, in the last decade it has become clearer that certain brain injuries and organic mental disorders result in syndromes that for all practical purposes appear to be personality disorders. Still other findings from diagnostic tools such as the Positron Emission Tomography (PET) scanner demonstrate that some personality patterns result from unusual patterns of use of specific parts of the brain. For example, obsessive compulsive disorder shows disproportionate use of the dominant hemisphere anteriorly. There is also evidence that at least some personality characteristics and personality disorders are able to be biologically inherited.

Nevertheless, it is clear that personality disorders result from difficult upbringing and from problems in relationships in early childhood in many cases. The most serious personality disorders include borderline personality disorder, which is thought to arise from difficulties in the first stages of life. People with this problem have extreme problems with anger, and are prone to suicidal and homicidal behaviors in addition to unusual sexual behaviors and drug and alcohol abuse. Antisocial personality disorders are prone to criminality and tend to regard other people as objects to be used, rather than as other real people. Histrionic styles are narcissistic and dramatic. A variety of other maladaptive personality disorders and styles have been described in the non-Indian culture. Although personality disorders clearly exist among American Indians, little work has been accomplished in describing and categorizing these disorders. It is not known, for example, whether personality disorders among American Indians have the same symptom clusters seen among non-Indians, or whether some other unique clusters of symptoms specific to tribal or cultural groups exist. It is also not known whether the criteria for the diagnosis of a specific personality disorder by a person of one culture for a patient in another culture has any validity. For practical purposes, personality disorder diagnoses are used by Indian mental health program staff in order to provide a practical working tool for certain patients. However, until personality disorders among Indians are actually studied rigorously, the use of these diagnoses must be considered provisional.

Course: Personality disorders tend to be life-long and fairly constant. Persons suffering from personality disorders tend to be unaware that their difficulties arise from their own behavior patterns, but often see difficulties as the fault of others. Personality disorders are responsible for many of the ills of the world, from homicide and other crimes to difficulties in the workplace.

Treatment: Treatment for personality disorders relies upon long-term, specialized psychotherapy. This level and type of psychotherapy is usually beyond the skill level of the average practitioner in the field. Managing, as opposed to treating, many personality-disordered patients is possible for field staff, however, even management of personality-disordered patients requires specialized training and should not be attempted by those without specialized training. Recently, some problems that had previously been considered personality disorders have been found to respond to particular medications. Particularly the British have found that atypical depressive personalities respond to MAOIs and that obsessive-compulsive disorders respond to the drug clomipramine, which has just been released in this country. Some forms of psychotherapy are reported to provide patients with personality disorders with more effective coping skills. These therapies include interpersonal therapy, assertiveness training, some forms of psychosocial rehabilitation, and others.

Epilepsy and Related Disorders

Several forms of epilepsy have predominantly psychiatric symptoms. In particular, epilepsy with distribution in the parietal and temporal lobes presents with symptoms of a psychiatric nature. Symptoms may resemble panic disorder, psychotic symptoms, or unprovoked and undirected aggression. The role of mental health staff in working with this disorder is to recognize that the cause may be epileptic in nature and to differentiate epilepsy from other disorders so that adequate treatment can be obtained. This is possible if a good, systematic mental status examination is performed, and if the clinician knows the characteristics of these forms of epilepsy.

Course: Epilepsy can be idiopathic (i.e., of an unknown cause) or can result from localized lesions in the brain. The course may either be benign or may, in rare cases, represent a tumor or a bleed into the brain. Seizures may also be produced by a variety of medications, toxic states, and even withdrawal from alcohol and other habituating drugs.

Treatment: Treatment for various forms of epilepsy is fairly effective. Definitive evaluation must be performed by a neurologist or a psychiatrist with sub-specialty expertise in epilepsy. Treatment is carried out with anticonvulsant medication.

Sleep Disorders

Sleep disorders represent a heterogeneous group of disorders which are often missed or mistaken for other disorders, and which may be life-threatening. By far the most common sleep disorder seen in the clinical setting is the product of major depressive episodes, usually presenting with multiple nocturnal awakenings or early awakenings, but sometimes causing

too much sleep. For chronic sleep disorders, the use of "sleeping pills" is either ineffective or can produce organic mental disorders in the elderly.

More dangerous, however, are sleep disorders such as sleep apnea. Sleep apnea is caused either by a compromise of the respiratory center in the brain stem (such as occurs in diabetes) or as a result of mechanical obstruction of the respiratory tract when the patient enters the REM (Rapid Eye Movement) phase of sleep. This dangerous disorder causes high blood pressure, right-sided heart failure, and a reversible dulling of the intellect. The oxygen level in the blood often reaches dangerously low levels before the rise in blood carbon dioxide causes the person to awaken. Many of these people wake up hundreds of times a night in small "micro-awakenings," yet have no memory of interrupted sleep. The person may complain that he or she is sleepy almost all the time. It is particularly critical to recognize this disorder, because the sleeping medications a patient might otherwise use may depress the respiratory drive even further and kill the patient.

Sleep disorders such as the above can be definitively diagnosed in a sleep laboratory. All (including major depressive episodes) have characteristic findings on the sleep record. However, a clinician with adequate training can differentiate these disorders on at least a provisional basis from the patient's history and by obtaining information from the spouse. Certainly the clinician without training should not attempt to manage these sleep disorders because of the risk to the patient's life resulting from the improper use of "sleeping pills."

Course: The course of sleep disorders depends entirely upon the cause of the disorder. Sleep disorders resulting from depressive illnesses follow the course of the depressive illness. Sleep apnea tends to continue to make the patient's physical symptoms worse, and may endanger the patient's life because of falling asleep while driving or on the job. It is not known how many people die in their sleep as a result of severe sleep apnea or of inappropriately prescribed medications that depress respiration. Situational disorders produce sleep problems (usually difficulty getting to sleep) that tend to resolve spontaneously after a relatively brief course. Other sleep disorders, such as delayed sleep phase disorder and narcolepsy have very different courses and treatments.

Treatment: Treatment of sleep disorders takes place in three phases. First, the clinician in the field must be sufficiently astute to recognize that sleep disorders require further diagnostic efforts. At the level of the individual clinician, many sleep disorders can be diagnosed with a good history and examination. More complex disorders, such as sleep apnea, generally require referral to a sleep laboratory for definitive diagnosis. Sleep apnea, potentially the most serious of the there disorders, requires the use of medication, or--in severe cases of the obstructive subtype of sleep apnea--surgery to reconstruct the airway. In the case of some sleep disorders, clinicians can "cure" the patient by relatively simple means, such as keeping the patient awake for a night in the case of delayed

sleep phase disorder. The treatment for some sleep problems related to situational disorders may be as simple as helping the patient do nothing to alter sleep while waiting for situational problems to resolve.

Hysterical and Histrionic Disorders

This group of disorders appears to be relatively uncommon among Indian people. Under current diagnostic criteria of the DSM-III R (Diagnostic and Statistical Manual, Third Edition, Revised), conversion disorders are separated from dissociative disorders, even though they may often be found in the same individuals. In the conversion disorder, people develop isolated losses of the function of limbs, blindness, or deafness, or other neurological-appearing symptoms with a psychological basis. Multiple personality disorder, which is rare in the non-Indian population has not been reported among Indian people. The diagnostic validity of histrionic personality is questionable in Indian adults, because of the difficulties with personality disorder diagnoses applied to the transcultural setting noted above.

Course: Conversion disorders may be isolated responses to severe emotional stresses and conflicts, or may be part of a larger pattern of illness such a somatization disorder. More complex disorders of this group tend to be stable and may be quite disabling.

Treatment: Specialized techniques of therapy, such as hypnosis and some forms of traditional healing, are highly effective in treating isolated conversion disorders. Treatment of multiple personality and more complex disorders of this group become more difficult, specialized, and prolonged to treat. Psychodynamic psychotherapy has a long and distinguished history in the therapy of these complex disorders.

Neuropsychological Disorders

Localized death or dysfunction of brain tissue produces a host of patterns of disorders with very specialized presentations and treatments. For example, a one or two square centimeter injury to the anterior speech center of the left hemisphere in a right handed person will produce a difficulty in remembering the names of objects. Further back along the same hemisphere of the brain, an injury will produce fluent speech with good words, but no overall intelligible content of speech. A scar on the inner aspect of the right temporal lobe will destroy the ability to understand music, while an injury a few inches forward and upward will cause a loss of the ability to understand complex social situations. The brain is well mapped but highly complex, and injuries may include a combination of a number of functional losses. Injuries to the brain may be present at birth, or may result from later physical trauma to the brain, infections, tumors, and strokes. These localized syndromes appear to be present in significant numbers on some reservations, often resulting from head trauma from automobile

accidents and other causes. In spite of the common presentation of these disorders on some reservations, little work has been done researching the frequency and types of these problems on reservations or among Indian groups. There is clearly a need to develop relatively culture-free neuropsychological instruments to detect and categorize specific kinds of brain injury among Indians. Currently available diagnostic instruments depend upon a person's mainstream American educational and cultural background to answer many questions correctly on the instruments.

Diagnosis of neuropsychological disorders is accomplished in several ways. Computerized tomography scanning and magnetic resonance imaging are vehicles for localizing the injury. Psychiatrists and behavioral neurologists can localize lesions through structured evaluations. A neuropsychologist, using one of the several structured testing batteries, can match the neuroradiologic procedures for diagnostic accuracy. Unfortunately, there are no neuropsychologists currently associated with the IHS. We have no idea of the actual impact of these disorders on Indian communities, although informal reports tend to suggest that the impact upon Indian communities may be substantial, particularly damage to memory circuits resulting from nutritional deficiencies (e.g., thiamine, B-12, folate) associated with alcoholism and from injuries resulting from accidents and violence.

Course: Like many other disorders in this report, the course of neuropsychological disorders depends upon the cause. In a child, many of these disorders will be bypassed, and the child will learn to use alternate pathways in the brain to accomplish specific tasks. In adults with acute injuries, some recovery takes place in the same way and through other complex mechanisms of rerouting neural pathways. Tumors and infections must be diagnosed quickly with the hope of stopping them. Disorders such as multiple sclerosis and multi-focal leukoencephalopathy have courses that are managed symptomatically.

Treatment: Treatment for these disorders can be conceptualized in several phases. The acute phase of any localized disorder of the brain is an intense hunt for the cause, and subsequent management of the offending agent. Many of these hunts for the offending agents and subsequent treatments are highly technical and require inpatient neurologists, neurosurgeons, and neuroradiologists. However, mental health staff in the field can often be critical in the early detection of localizing lesions. Disorders related to the nutritional deficiencies associated with alcoholism can be treated on an acute basis by a variety of specific nutritional and pharmacologic measures, but may become permanent if not treated early.

Treatment of the residual symptoms of localized brain lesions is another specialized treatment technology. Depending upon the location of the injury, teams of psychologists, physical therapists, occupational therapists, speech therapists, and others may be required to help the patient regain functioning. Indian Health Service has some of these services in

several isolated areas in the country. Other areas have difficulty purchasing these services because of their long-term expense, and because "rehabilitation" has received low priority from IHS headquarters in the past.

Phobias

Phobias are unreasonable and repetitive fears that cause substantial impairment in the person's life. There are three general types of phobias and different ways in which phobias arise. Simple phobias usually arise in childhood in an otherwise normal person as a result of a frightening event. Typical simple phobias include such fearful objects as snakes, spiders, dogs, and similar objects. Nevertheless they can cause the person to severely limit their lives in order to avoid the fearful object or situation.

Agoraphobia usually arises from panic disorder in the manner described under the panic disorder section of this chapter, and results in fears of crowds, fears of certain forms of transportation such as airplanes and driving, and fears of leaving "safe" places and people.

Social phobias are the least-understood group of the phobias. Disorders in this group include a fear of signing the person's name in public, fear of public speaking, fear of urinating in public bathrooms, and other fears that may cause substantial difficulty and disability to the afflicted person.

Course: Simple phobias are generally stable, but may fluctuate with other life stresses. Agoraphobia may have a highly variable course, with some individuals having little disability and others having very substantial disability for most of a lifetime. Social phobias run an equally variable course.

Treatment: Behavioral techniques such as systematic desensitization, flooding, and similar techniques have been demonstrated to have a marked efficacy with the simple phobias. The treatment of agoraphobia is described elsewhere in this monograph. Social phobias are treated using a variety of techniques derived from the other phobic treatment technology, including desensitization, "in vivo" exposure to the phobic stimulus and cognitive techniques.

Disorders Specific to Particular Environments

A variety of problems arise in specific environments, and a variety of technologies have evolved to deal with them.

Family problems: A variety of problems ranging from a lack of parenting skills to eating disorders in children and adolescents may result from problems in family interactions. Unhealthy family interactions and communications styles have been shown to exacerbate and possibly even lead to the development of major mental illnesses, in susceptible individuals. Therapies of several sorts have been devised to deal with these problems, which are often linked under the general heading of "family

therapy." Many times, family therapy is the only effective tool to deal with troubled family members. Contrary to widely held belief, those who have attempted family therapy with Indian patients have found it to be highly effective. Recent work has also demonstrated that family education models may be as effective as "therapy" models in some cases, although the author knows of no cases in which these educational models have been used in Indian programs.

Couples problems: Couples with problems respond to a variety of "conjoint" therapy techniques. Often these techniques can help couples stay together, or at least part without rancor.

Cultural adaptation problems: A variety of techniques are effective in helping people overcome stresses and problems related to adapting to different cultures. Many of these techniques have been developed by transcultural psychiatrists, transcultural psychologists, and medical anthropologists. The author has also encountered sophisticated systems by which some Indian cultures teach their children to deal with non-Indian cultures. These systems teach non-Indian body language, customs of speech and dress, and other aspects on non-Indian culture. These culture-specific techniques may be very therapeutic, but their effectiveness is largely undocumented at present.

Work-related problems: A variety of technologies have been developed to help cope with mental health and alcohol and drug problems related to work. The IHS has developed a model program demonstrating this technology for in the Billings Area, under the leadership of Christine Peterson, M.S.W.

Disorders Specific to Childhood

Children's mental health issues may be the largest single unmet health need for Indian people today. So few resources have been devoted to the mental health of Indian children that we have only vague ideas of the extent of these problems, and only the glimmering of an idea of what to do about them. The few pieces of information that we do have are frankly frightening. Perhaps the most significant article that has appeared to date was the review in the *White Cloud Journal* of Indian childrens' mental health issues by Green, Sack, and Pambrun (1981)(please see suggested readings). Levels of severe emotional disturbance among Indian children have been estimated at 25%. With more than half of the Indian population in the childhood and adolescent age ranges, this implies that 12% of the Indian people in the country are children and adolescents who suffer from virtually untreated severe mental health problems.

The above noted figures are at first difficult to believe. However, other indirect evidence tends to support this contention. Indian adolescents in some parts of the country run from 20 to 50 times the risk of death from suicide in comparison with non-Indian adolescents, for isolated periods of time (e.g., during suicide panics). The risks for a variety of negative

outcomes for Indian children and adolescents is higher in a number of categories than for non-Indians, and we are only beginning to understand the scope of problems such as sexual abuse among Indian children. It is difficult to image a more significant group of problems for the future of America's Indian people. Yet nationally, only about 10% of all the mental health services provided by IHS is to children. Given the type of staffing actually in place in the field and the lack of systematic methods to evaluate and treat Indian children and adolescents, one wonders about the quality and value of those services. For example, most mental health clinicians working in Indian programs today are trained in the diagnosis and treatment of mental health problems of adults but have little or no training to deal with mental health problems of children.

Childrens' services tend to be more specialized and less systematic than mental health services for adults. The state of the art in childrens mental health has been noted to be decades behind adult mental health in developing systematic categories for the diagnosis of major mental disorders. This lack of precision in child and adolescent mental health may be attributed to several factors, such as the complicating effects of multiple lines of development having an effect upon and being influenced by major mental disorders and environmental conditions in a more dramatic fashion than in adults. As a result, many clinicians in child and adolescent mental health have argued that diagnosis is irrelevant because each child or adolescent is entirely unique. Because treatment outcome studies are based upon diagnosis, if carried to an extreme, this stance would prevent the development of a child and adolescent epidemiologic and treatment outcome literature. In fact, these difficulties have resulted in a chaotic state of development in child and adolescent mental health technology which has yet to arrive at a standard, agree-upon diagnostic system. For this reason, treatment of children and adolescents tends to be less amenable to systematization and teaching than is adult mental health. There are also far fewer trained children's and adolescents' mental health professionals in the nation, and as a result, their services tend to be quite expensive. There are no more than a handful of mental health professionals with special training in childrens' issues in the IHS or working for tribes.

The diagnostic criteria that do exist for children are less specific than for adults. There are several reasons for this. Children's mental states are highly subject to issues of development in several spheres, such as cognitive development, development of the sense of "self," and physical development. A child's problems at one age often return to normal at other ages. In addition, severe pathology may not be accurately diagnosed because of a lack of knowledge in this field. Two adolescents that present with identical psychotic symptoms may go on to develop two different illnesses over the long term, such as schizophrenia and bipolar affective disorder. Drugs and severe emotional pathology frequently come together in adolescents, and it is often impossible for clinicians to distinguish the

effects of these drugs as a symptom rather than a cause of affective or psychotic symptoms.

A number of recent studies shed light on the state of both Indian and non-Indian children's mental health. For non-Indians, studies such as those by Puig-Antich (1982) and those conducted in the North Dakota (Fisher, Burd & Kerbeshian, 1987) shed some light on basic epidemiologic issues of child and adolescent mental health in America. Examples of the diagnostic difficulties in children and adolescents can be seen, for example, in the overlap of the categories of conduct disorder and depression. It has been found in this case that conduct disorder behaviors can be a symptom of depression in adolescents, rather than a discrete diagnostic entity.

These problems are highlighted in current efforts to begin a children's and adolescents' Epidemiologic Catchment Area study in the United States, and difficulties in developing the instrument for such a study. The Diagnostic Interview Schedule for Children (DISC), which has undergone a number of major revisions, is still the subject of much controversy.

Recent efforts to explore the mental health of Indian children have focused upon the Flower of Two Soils study of Canadian and United States Indian children (Sack, Beiser, Clarke & Redshirt, 1987). Some results of this study have been published (see suggested readings), but the major portion of the data from this study has yet to be published.

However, several diagnostic categories and groups of problems are recognized among children and adolescents, and these form the basis for the beginnings of a child and adolescent diagnostic and treatment system. The categories listed below roughly follow those of the DSM-III-R, even though for child and adolescent disorders, this diagnostic system admittedly remains controversial.

Developmental Delays

Children develop along a number of interrelated yet identifiable developmental lines. The more obvious lines of development include the growth of the child's body, and gross physical coordination. At the same time, fine physical coordination and the development of intellectual skills can be identified as specific developmental lines. These intellectual or cognitive skills, in turn, are related to the development of speech and different aspects of the personality. The different aspects of the personality all have identifiable stages that are interdependent. Psychosexual development, development of the ego or self-identity, and the development of the ethical sense all have well-known developmental pathways with identifiably behavioral landmarks. Social skills also have identifiable stages of development that are related to the development of the personality.

At any particular age, it is possible to identify the expected development of the various aspects of the child in the majority culture. Developmental milestones for children from Indian and other non-western

cultures have not been well studied, and may be very different from commonly accepted milestones for "Anglo" Americans in several different developmental lines. There may be a variety of causes for the deviation from the expected developmental sequence, such as a child with hearing difficulty not developing normal speech, or a child with a neuromuscular disease not holding his or her head up or walking as expected.

In the development of the mind and personality of a child, there are a multitude of identified tasks and discrete phases. The ego or sense of self begins with the child bonding with the parent in order to get basic needs such as food, protection, and nurturing met. This bond is the basis for the protection of the child by the parent. The sense of self develops as the child begins to develop a sense of separateness from his or her parents, while at the same time having an emotional connection to them. This "separation and individuation" period of development forms the basis of the sense of self in later life, and disruptions during this period form the basis of several of the personality disorders.

The development of the child's psychosexual characteristics occurs simultaneously and is related to a number of discrete aspects of the personality, such as the child's relationship to others around issues of control, competition, and internally generated needs to achieve. In addition, another formulation of developmental lines emphasizes the sequence of the development of basic trust, autonomy, industry, etc.

Intellectual development begins with the integration of the senses and muscular movement systems. It proceeds along lines of increasingly sophisticated comprehension until at least the early teens, at which time the child should be capable of abstract thought.

Problems along any of these developmental lines must be identified early and the cause determined in order to treat developmental delays. Often a delay along a single developmental line points to a specific cause, such as the delay in speech acquisition resulting from high-frequency hearing loss. More often, however, difficulties in one developmental line influence development along several lines. For example, in the classic British "foundling home" study of about 40 years ago, the lack of early physical and emotional contact with a caring adult in the first few months of life was found to have effects so severe that children without "bonding" died in a relatively short period of time from infections and other causes.

The task of the mental health staff member is to act as a member of a team to track down and repair the damage in the child's development. It is essential that the mental health staff person act as a member of a team because of the large number of medical and neurological conditions that can contribute to developmental delays. In some cases, the detective work that goes along with developmental assessment leads to a finding of the need for alteration of the child's physical environment or social conditions. Mental illness in a parent such as depression or substance abuse may cause significant developmental problems in the child, and it therefore becomes the task of the mental health staff member to intervene in the

child's world in order to restore the child's development to normal. In this example, treatment of the parent's mental illness may be the main intervention needed by the child.

Working with Indian children is a distinctly harder task than working with the assessment and treatment of the development of non-Indian children. Most of the research work into developmental norms has been done with European and American children. Relatively little is known about the intellectual development of children who grow up with an intellectual framework of the American Indian languages. Indian children appear to lag behind Anglo children in the development of certain language skills among other things, but may be ahead of their European counterparts in other developmental areas. Whether these differences are the result of differences in the development of the brain itself, or are purely the result of cultural differences in child-rearing remains to be determined, although it is the subject of much speculation. Likewise, child-rearing practices in many traditional Indian cultures are very different from the nuclear European family upon which most of the developmental literature is based. It is clear that the development of a child in an extended family or grandparent-based family can produce healthy, happy children. However, the question of what constitutes normal development in this environment has not been determined, much less what is abnormal and how it might be helped. In non-Indian cultures, developmental norms have been sufficiently studied so that specific developmental measurement tools are available to the average practitioner, such as the Denver Developmental Screening Test (now improved as the Denver II), or the Boyd test. However, it has been shown by psychologists (Dinges & Hollenbeck, 1978) that the cultural bias of such tests makes them largely invalid for Indian children. Much work needs to be done on re-norming existing tests for Indian children or to new instruments that will be valid for a range of Indian cultures before developmental assessment of Indian children becomes a tool available at the average Service Unit.

An additional difficulty in correcting developmental delays is the lack of children's mental health staff in the IHS and tribal programs. At the masters level and below, little or no specific training is given to adult mental health workers in assessment and intervention for developmental delays, or in other childrens' mental health problems. Even among doctoral-level adult mental health practitioners, training in children's mental health is much less substantial than is needed for practitioners to exercise a high degree of virtuosity in assessing and intervening with developmental delays of children. Without good testing instruments for Indian children, we must depend upon the skills of a handful of such staff in IHS, and the average program probably does not know that they even exist, much less have the ability to use their skills.

Good models for traveling developmental assessment teams exist and are in operation in some Areas. However, these teams present substantial financial costs to the tribes and IHS, and they are not the ultimate

solution to providing interventions for developmental delays because of other logistical problems, such as having local staff follow up on treatment recommendations. The development of good testing instruments for Indian children and adolescents would do much to make the efforts of these teams go further.

Learning Disorders

Like developmental delays, learning disorders represent a wide range of specific problems arising from a variety of causes. The final common pathway for all these processes is the difficulty in accomplishing specific educational goals for the child. The most widely recognized of these learning disorders is dyslexia, a condition with a functional neurological basis in which left/right confusion prevents the child from orienting correctly on the printed page and gives the child major difficulty distinguishing letters and numbers that differ only in the direction in which they are facing, such as "b" and "d." Other learning disabilities involve difficulties with arithmetic and with spacial relationships.

Emotional and environmental problems may often resemble or contribute to learning disabilities. Educational psychologists and special education teachers generally have the task of sorting out the causative factors for these problems and designing interventions to help the child overcome them. However, children often develop a variety of other developmental and emotional problems as a result of the school difficulties, such as problems with peers and family resulting from the learning disorder. Children's mental health specialists are often needed to unravel the other difficulties arising in conjunction with learning disorders.

Indian children are somewhat better off than some non-Indian children in the United States in having help for the learning disorders. The BIA has specific programs for these children; however, currently there is a gross under-funding of many of these programs because much of the money has been diverted to the states under the block grant system with the understanding that the funds will be used for Indian students as well as non-Indians. In few, if any, states do Indian children receive a fair share of block grant education money. In a great number of cases, the states have failed to provide these legally required services to Indian children, and though they have lost a number of legal actions on this issue, continue to fail to provide the services to learning disabled Indian children.

IHS is only peripherally involved with learning disabled children because by law the responsibility for these children belongs with the BIA and the states. However, IHS and tribal mental health staff does become involved because they are sometimes the provider in the Indian community with the greatest knowledge of the neuropsychology of the various learning pathways. The local mental health professional may have the greatest skills in intervening in the emotional problems of the child and the family. At the very least, the IHS staff must provide a link between the treatment system

and the school system to ensure that continuity of care for these children is maintained.

Mental Retardation

Like learning disabilities, mental retardation is defined as being the province of the states and the BIA, although the IHS is often involved in the diagnosis and care for these people. Mental retardation is defined as an intellectual performance a certain amount below the expected performance for the person's age. Unlike learning disabilities, mental retardation is generally pervasive in the functioning of the brain. A multitude of known causes for mental retardation exist which include inherited disorders of metabolism, fetal alcohol syndrome, chromosomal abnormalities such as Downs Syndrome, or birth trauma such as a lack of oxygen from a twisted umbilical cord at birth.

Depending upon the cause of the mental retardation and the location of the damage to the brain, other disabilities may be present in the mentally retarded person. Certain types of brain injury may produce movement disorders such as cerebral palsy, or sensory deficits like blindness and hearing loss. Progressive forms of mental retardation are often fatal early in life, although some causes of retardation such as that resulting from phenylketonuria (an inherited metabolic disorder often referred to as PKU) or hypothyroidism are treatable in part or completely. By the time the child enters school, the treatability of most of these conditions has vanished and the damage is done, so it is vital that these conditions be recognized and treated as soon as possible in the child's life.

A number of IHS and tribal programs have undertaken some of these critical identification and treatment functions for mentally retarded children, for which they receive little or no funding. Maternal Child Health programs and Community Health Nurses employed by IHS and the tribes play a critical role in identifying and obtaining treatment for mentally retarded children and infants. However, in assessing and treating neuropsychological difficulties, mental health programs must play a greater and more sophisticated part in the early identification and treatment of this underserved population.

A unique role for mental health in working with mentally retarded persons is necessitated by the increasing awareness that a large percentage of these individuals suffer from concurrent major mental illnesses. Psychotic conditions, partial complex seizures, episodic aggressive outbursts, and affective disorders such as depression are all present and treatable in the mentally retarded population. Treatments such as behavioral interventions and specific medications that are useful in the general population are perhaps of even greater benefit in the mentally retarded population. Even a slight improvement in the person's functioning may have major implications for the ability to learn new skills, to live independently, or to survive in a family setting. For a mental health

professional, additional specific training in mental health care for mentally retarded persons is needed because of differences in responses to treatment intervention among the mentally retarded, including paradoxical response to sedating medication with agitation, different types of medication needed for people with compromised neurological functioning, etc.

The BIA is even more hindered than the IHS in its ability to provide needed services to the mentally retarded, in that the specialists needed for these services are expensive and are rarely hired by the BIA. However, by providing a small amount of training to competent mental health staff, these staff members could be of substantial benefit to Indian people who are mentally retarded. This is likely to happen only as a result of major policy change or extensive interagency agreements, however.

Affective Disorders

With the increased recognition of the biochemistry and genetic components of affective disorders in adults, there has been a recent increase in the understanding and recognition of these disorders, particularly depression, in children. Depressed children tend to be found in families in which there is a high frequency of depression among the adults, testifying to the potential contribution of genetic factors to childhood depression. However, childhood depression is in may ways more complex than depression among adults. It is widely thought that losses and disturbances in development contribute to the development of depression in children. Whether biological and "developmental" depressions represent entirely different diagnostic entities with similar symptoms as seen by the clinician, or whether losses and other critical trauma during development can re-program the development and function of the child's brain remains an open question.

Childhood depression is further complicated by the lack of specificity of symptoms. Depressed children do not often demonstrate the sleep disorders that are characteristic of adult depression, but may have other sleep problems. Eating problems may likewise present a confusing picture. Often a predominant feature of childhood depression is temper outbursts, oppositional behavior, and concentration difficulties that all may be confused with other disorders, of childhood such as conduct disorder, learning disorders or oppositional disorder. While childhood depression can be diagnosed with some reliability with the same blood tests that are helpful in depressed adult patients, the great majority of the children in whom the tests would be useful are never considered to have depression. The thought that the child might have depression rarely enters the mind of the majority of practitioners, and even more rarely does the child receive treatment.

Further complicating the picture of childhood depression, as well as other major mental disorders in children, is the tendency of service providers, clinicians, parents, educators, and others to focus on the

behavior of the child rather than the child's internal state. This may take the form of examining the end points of behavior, such as suicide or defiant conduct, while ignoring treatable mental disorders such as depression that may be causing the behavior. Another unfortunate source of confusion has been caused by publicity over general symptoms of temper problems, troubles in school, fighting, oppositional behavior, and concentration difficulties as signs of "chemical dependence" in children and adolescents. While these symptoms may be seen in children and adolescents who use alcohol and drugs, they may also be seen in other disorders such as depression. This diagnostic confusion may be very damaging when the already depressed, drug-free child or adolescent is accused of drug abuse by an over-confident adult. The consequences of diagnostic confusion in childhood and adolescent depression are sad, in that they deny effective recovery to these children and adolescents in critical developmental periods, and may contribute to rates of significant death and disability.

Fortunately, screening tests are becoming available that may help to detect depression reliably in children and adolescents.

Course: The course of childhood depression has not been explored and written about to the same extent as depression among adults, perhaps because of diagnostic uncertainties. We know that the great majority of the children with this problem must recover without significant sequelae. We do not know the average duration of depressive episodes among children of different ages. We do know that a number of the children who attempt suicide each year suffer from this disorder, and it is suspected that depression predisposes children to the development of other disorders and difficulties, such as school difficulties.

Treatment: The treatment of depression among children is less well studied than depression among adults. The tricyclic antidepressants are used effectively in small doses with children but are not altogether without risks. The psychotherapy of children with depression is based upon the relationship with the therapist, but family therapy and group and activity therapy are also used with what appears to be positive results. New therapies, such as cognitive therapy for depression in children, hold much promise, but have not been well studied.

Attention Deficit Disorder

The public is perhaps better aware of this condition than many in child mental health, though it remains controversial in some ways. The public often thinks of this condition as "hyperactivity," although the child with attention deficit disorder may or may not be "hyperactive."

The child with attention deficit disorder is characterized by a lack of attention, manifested by difficulty finishing things started, difficulty listening, easy distractibility, and difficulty sticking with tasks requiring sustained attention (even difficulty sticking to play activity). For example,

children with this disorder often cannot sit through a whole half-hour cartoon show, even if it is their favorite program.

Children with this problem are impulsive in that they routinely act before thinking, shift between activities excessively, have difficulty organizing work, call out in class frequently, and have trouble taking turns in class or in games. Parents and teachers often find that these children need a great deal of supervision. Children who also have hyperactivity are noted to run around excessively or to climb on things more than usual, have difficulty sitting still or staying seated, move excessively even in sleep, and are described by parents and teachers as being always "on the go" as if driven by a motor.

This disorder is thought to be the result of a lag in the maturation of a pathway in the brain that controls activation levels of the cerebral cortex. Because of the nature of this pathway, these children respond in a different manner to stimulating drugs than adults or other children. The well-meaning general practitioner sometimes prescribes sedatives for these children and is surprised to find that the attention deficit and activity levels get even worse. On the other hand, medications that would be strong stimulants in adults or other children act in hyperactive children to return their activity levels and attention to normal, or even to act as sedatives.

Perhaps the greatest problem with this condition lies in its diagnosis. At certain developmental stages, and as the result of other problems, children may appear to be distractible or "hyperactive" although they really do not have an attention deficit disorder. Children who may be anxious as the result of depression, phobias, or other causes of anxiety, do not respond well to stimulants in most cases. For several years attention deficit disorder was over-diagnosed and stimulant medications were mis-prescribed to children who really needed help with other problems. Many child psychiatrists now believe that the public "backlash" in the diagnosis and treatment of this disorder has resulted in widespread unclear diagnosis and under-treatment.

Indian and non-Indian children suffer from this condition. It is this clinician's impression that the course of the condition differs widely according to which Indian culture the child belongs. In rural areas, these children are often left to play outside more than urban children. This results in fewer parental complaints about the child, but the child appears at the emergency room more frequently than average for the repair of broken bones, lacerations, etc. In Indian cultures that place a high value on the child's compliance and respect for elders, these children may suffer significant rejection.

Although popularized in the lay press, the child psychiatrists and behavioral pediatricians tells us that there is to date no good evidence that sugar intake is at all related to activity levels in the hyperactive child. The extent of the public belief in this theory, however, creates a situation in which clinicians may have to live with parents' theories to this effect.

Course: In many, perhaps most, cases of this disorder, the maturation of the brain improves the condition in the long run. It is increasingly recognized that in some cases the hyperactivity disappears, though many of the signs of attention deficit remain, creating difficulty with education and future job performance. The impulsivity of the people with this residual disorder also creates problems in social and occupational function, and not infrequently leads the adult to have legal difficulties.

Treatment: Good treatment for this condition rests with the accuracy of the diagnosis and the attitudes of parents and teachers. For a child who really does suffer from attention deficit disorder, the response to stimulant medication is often very dramatic. The child who everyone suspects is a "bad" child suddenly becomes "normal" in the eyes of the adult world, with a resulting improvement in his or her life situation.

Problems in the treatment of hyperactive or attention deficit disordered children are made more difficult because of the popularity of this condition in the lay press, the misdiagnosis of the condition, and the resulting mis-prescription of stimulants. On some reservations, these factors have combined to make the appropriate prescription of Ritalin and the other medications for this condition impossible, due to public unpopularity of these medications. As a result of public opinion, the clinician must resort to the use of secondary medications such as the tricyclic antidepressants, which are effective, but which have greater risks than the first-line medications for this disorder.

Even if the medications are effective, work with the child's family is important. By the time that the child comes to the attention of the health care system, the family is usually very unhappy with the child. Work is almost always required in helping the family learn cope with the child and his difficulties.

Psychotic Conditions of Childhood

As with the affective disorders of childhood, there is increasing recognition of the presence of psychotic conditions among children. Among of children labeled "mentally retarded," there is a group in whom psychotic thinking interferes with other thinking processes. These children may look more severely retarded than they actually are, and are often difficult to manage because of violent outbursts and self-destructive behaviors. For the group that suffers from childhood schizophrenia, the long-term outcome is not good. However, children with toxic or other organic reasons for their psychoses can benefit significantly from treatment for their psychotic symptoms. Autism is often confused with both childhood schizophrenia and mental retardation.

Fortunately, childhood psychoses are relatively rare. On reservations or schools with a significant population of the mentally retarded, however, there are likely to be children whose psychotic thinking is more amenable to treatment than other symptoms of mental retardation.

Because of this, children suspected of suffering from mental retardation deserve good evaluations by child psychologists, child psychiatrists, or other physicians who specialize in the treatment of these children. Ideally, all mentally retarded and psychotic children deserve early identification and evaluation.

Autism

Autism is a poorly understood condition that may resemble mental retardation, but may sometimes occur in children with normal or above normal intelligence. It is characterized by often severely disordered communications with the world, extreme difficulties understanding social events in the environment, and an insistence on absolute sameness in the environment over time. These children may not develop language and are often bizarre in other ways. The cause of autism is unknown, and treatments are based on intense environmental programs. Some researchers believe that autism is caused by a virus or severe metabolic problem in the brain. The frequency of autism in Indian children is not known.

Eating Disorders

Eating disorders do occur in Indian children and adolescents, although these were not recognized until the spring of 1986 when they were reported by Dr. Michael Biernoff at a national meeting. There are several types of eating disorders present among Indian children and adolescents: anorexia nervosa, bulimia, and pica. The two most significant are anorexia and bulimia. Anorexia nervosa falls into two types. Type I is considered to be the result of excessive control by the parent, usually the mother, with a perfectionistic child upon whom demands for high achievement are relentlessly placed. Type II anorexia nervosa is thought to be the result of peer pressure among adolescents. Both types occur in non-Indians with a sex ratio that produces nine cases out of 10 in women. In Indians both types of anorexia nervosa have been seen by this clinician, but the Type I anorectics seem to have been more frequently the result of control and pressure to achieve from grandmothers in strongly matriarchal cultures then as a result of excessive parental control. Anorectics literally starve themselves, sometimes to the point of death. They gain a distorted body image and see themselves as disgustingly fat even when on the verge of death from starvation. They often exercise compulsively and take laxatives to make sure that none of the food is absorbed. A male version of anorexia may be seen among young men who exercise to the point of tissue destruction and extreme thinness. In non-Indians (and perhaps among Indians) excessive exercise may be a new variant of anorexia.

Closely related to anorexia is bulimia, a condition in which the person overeats and then induces vomiting. These people get into trouble

not only from starvation, but from often severe disturbances in their plasma electrolytes, since vomiting depletes the body of several electrolytes, particularly the chloride ion. Although these disorders are present in Indians, it appears likely that the frequency is less than in the non-Indian population.

Pica is a disorder in which children eat non-food substances such as chalk, dirt, or paper. Pica occurs in Indian children either as a symptom of other disorders or on its own. Little is known about the frequency, unique symptoms, or causes of this disorder in Indian children.

Attachment Disorders

Although popular several years ago, major questions have been raised recently about the validity of this group of disorders. This group of disorders is the result of a lack of adequate parenting in the first year of life. As noted previously, children who have no other people with whom to interact do not survive well. A child younger than eight months of age who has attachment disorder is lacking any of the normal responses to people, such as recognition of faces, tracking the eyes of another person, lack of smiling, lack of reaching for the mother, weak muscles and feeding reflexes, and a variety of related symptoms. These children show poor weight gain in proportion to length and head circumference. They get better in even a mildly nurturing environment, such as a hospital.

Even if a little adult contact can remedy the more severe forms of attachment disorder, it is currently thought that failure to form an attachment with the mother or inconsistent nurturing may result in profound disturbances of the ego or sense of self. It is proposed that this inconsistent nurturing may lead to conditions such as borderline personality disorder. Borderline personality disordered patients show an inability to differentiate internal states from external events, and become often homicidally angry with others over an internal state. Likewise, they may commit suicide over a slight or injury from another person. They are angry people who use drugs and alcohol to excess, have diverse and unusual sexual lives, and are incapable of feeling satisfaction.

Attachment disorders may result from several sources. In some cases, they are the result of the parents, particularly the mother, being so disordered that normal biologically-based bonding between mother and child cannot take place. This may be related to parental alcoholism, severe drug abuse, psychosis, or severe depression. Unfortunately, parents who suffer from disorders such as borderline personality disorder themselves may be incapable of bonding normally with an infant. Thus, without a genetic or familial basis, the attachment disorder may be passed from generation to generation. (It has been speculated by some Indian mental health professionals that the boarding schools in the early part of this century, particularly when used for small children, deprived children of

models for healthy parenting and thereby increased the frequency of these disorders.)

Sadly, one sees a large number of what appears to be attachment disorders in developmental assessment clinics held on some reservations. When parenting problems come before the courts in the form of termination of parental rights for child abuse and child neglect, the disposition of the children into foster homes rarely produces a return to normalcy. The movement of these children through a series of foster homes clearly exacerbates their conditions, producing very unstable adults; yet the courts persist in this practice. As the child continues to fail to attach to an adult, his or her behavior becomes increasingly difficult to manage, creating a less adoptable or placeable child.

Course: As noted above, the most severe instances of attachment problems may be fatal. In less severe cases, or in cases that are partially reversed, the child may become an adult with an unstable personality structure. This clinician has seen infants who were able to bond with an older sibling of even four to six years of age with a fair outcome. In severely alcoholic families, the oldest sibling is often the most disturbed because of having had no one to whom to attach. In adults without adequate attachment, the picture may be severe as in borderline personality disorder, or may range to normal if later corrective experiences help create a bond and repair the early damage.

Treatment: The treatment for this condition sounds simple enough: a stable relationship with another, caring human being who can meet the needs of the child for food, interaction, and affection. However, in light of the disordered natures of severely pathological families, it becomes easier to wish for such a stable adult than to find one in the family who is not already burdened with a number of children. As a result, the best treatment for this condition becomes treating the problem in the parent which is interfering with normal interactions. In recent years, it has become common for health professionals, particularly nurses, to attend to issues of bonding in early parenting classes, and to teach skills by which the parent and child become attached. The effectiveness of this approach is not proven, although this approach seems very promising.

Anxiety

Anxiety in childhood can arise from a variety of problems and issues, some of which are normal in the course of development. In other cases, anxiety can result from fears around separation from the parent, such as school phobia or a variety of other phobic conditions. In yet other cases, what appears to be anxiety to the adult may be depression or even a childhood psychotic condition. Many of the causes of anxiety in childhood are related to the developmental stage of the child, and resolve or become relatively fixed with the resolution of the developmental conflict. For example, the pressure upon the early elementary school child to achieve

and to be industrious may be thwarted by the pressure by peers to conform to the achievement norms of the group. Anxiety will likely result as the child attempts to solve this dilemma.

Course: The course of childhood anxiety varies greatly with the cause, duration, and severity of the anxiety. As some modern child psychiatrists have observed, many troublesome periods in the development of a child come and go without any damage to the long-term development of the child. Anxiety surely is one of the more common of these passing problems. However, in other cases, the pattern can become habitual and lead to a life-long pattern of behavior related to anxiety or defenses against it. In yet other cases, anxiety can be a symptom of a far more serious problem, and the course of the anxiety will follow the course of the other problem, such as depression or psychosis.

Treatment: This is one of the conditions of childhood in which the non-psychiatric clinician may be tempted to prescribe a medication; this is not appropriate. There are a multitude of problems related to the failure to further diagnose and understand the cause of the anxiety. The diagnosis of anxiety is the bread and butter of most child mental health professionals who have a multitude of effective diagnostic and treatment tools to deal with this problem.

Phobic Disorders

The most common phobias among all children are the simple phobias. Objects of the phobias include spiders, insects, dogs, heights, water, and a variety of other environmental conditions. The simple phobia is usually a learned response to a powerfully frightening stimulus, which then becomes the subject of many internal cognitive repetitions and anticipation of the next contact with the fearful stimulus. Largely through internal rehearsal, the feared object becomes more and more fearful to the point that the child may avoid any situation in which the fearful stimulus might be encountered. For example, a child with a fear of snakes may develop extreme difficulty in venturing into the out-of-doors in the summer. The severity of the phobia is related at least in part to the extent to which the child's life and normal activities are hindered by the avoidant behavior.

Another phobia, though not perhaps a true phobia is school phobia. Generally, school phobia is related to difficulty in separating from a highly protective parent. There is some evidence that school phobias in childhood may place the person at risk for the development of one form of panic disorder in adulthood.

Social phobias are relatively rare in children, as is true of agoraphobia.

Indian children appear to be just as likely as non-Indian children to suffer from simple phobias. This clinician has seen school phobias in Indian children, though it is my impression that they are less common than among non-Indians.

Course: Some phobias resolve spontaneously, while others go on throughout the course of a person's life unless treated. Often a person will attempt to conquer phobic symptoms through the use of "counter-phobic" behavior. For example, a person with a fear of heights may conquer this fear by taking up mountain climbing, or a person with a fear of flying may become a pilot. As noted, school phobia in children is a different kind of phobia that may be more related to separation anxiety than to the simple phobias.

Treatment: As in adults, phobias tend to respond very well to behavioral and cognitive therapeutic techniques. The fears are faced gradually in the systematic desensitization techniques, or more directly in the implosion of flooding techniques. In the IHS and Tribal programs a number of psychologists are quite proficient with these techniques, particularly those who have trained at behaviorally oriented programs.

Conduct Disorders

Conduct disorders represent a persistent pattern of behavior in which a young person's behavior fails to conform to the norms of society. Aggressive conduct disorders involve persistent patterns of aggression against others, such as rapes or assaults, or a pattern of thefts involving confrontation with the victim. Non-aggressive conduct disorders involve repeated acts of truancy, running away from home, thefts which do not involve confrontation with the victims, substance abuse, and other repeated infractions of the rules, such as persistent lying.

Children with conduct disorders may be under-socialized and fail to form relationships with others, including peers. In socialized conduct disorders, in contrast, the child commit acts under the influence of peers, such as a gang.

Conduct disorders are surely found among Indian children. It is unknown, however, whether they are more or less common than among non-Indians. Furthermore, no one has yet addressed the question of defining some conduct disorders when the rules of a "minority" culture do not match the rules of the "majority" culture and the young person finds himself between the two sets of cultural norms. For example, fighting to defend one's honor or "face" is common throughout the rural West. The point at which this becomes pathological if the young person moves to the city, for example, is difficult to determine. For these reasons, the diagnostic validity of this group of disorders is much more subjective than other diagnostic groups. Likewise, a variety of major mental disorders and situational adjustment problems may produce symptoms of conduct disorder. In these cases, the diagnosis and treatment of the underlying condition may hold the key to treatment of the conduct disorder.

Course: Most of us are aware of young people who might have been considered to have a conduct disorder at a particular period in their growth, yet who became law-abiding adults of exemplary character.

Unfortunately, others go on to develop antisocial personality disorders with a life-long history of criminal or other antisocial acts. Because there is a lack of good predictability for the conduct disorders, this should be perhaps considered more of a behavioral description rather than a diagnostic category, with the same validity as other groups discussed above.

Treatment: The treatment of a conduct disorder depends upon a variety of factors, particularly the degree to which the young person can form relationships with others and the presence of other disorders. A young person who can form a relationship with a therapist may quickly change his or her behavior to conform to the behavioral standards expected by the therapist. For other children, a relationship with a structured peer group, such as the relationships fostered through competent recreational therapy programs, may help to overcome conduct problems. In yet other children, working with the family to re-establish parental control may prove to be highly effective. A variety of other approaches to the treatment of conduct disorders may also be useful, but an inept program run by a person without the ability to understand children and adolescents can solidify and consolidate the conduct disorder. Perhaps even worse is the all-too-frequent presence in inadequately supervised treatment programs of adult workers who themselves have antisocial personality disorders, or who suffer from unresolved conduct problems. These workers can effectively lead pliable young persons into more serious and long-lasting conduct problems. It is therefore necessary to be extremely selective in the hiring of therapists to work with conduct disorders of children and adolescents. Contrary to some of the current trends, "educational" approaches to the solution of conduct problems have little or no proven beneficial results.

Other "Personality" Problems

There are a variety of problems in children which if encountered in adults would be considered to be personality disorders. However, in children these disorders are not inevitably fixed and are therefore not considered to be the same as adult personality disorders. In many cases, however, these disorders may in fact progress to become the adult personality disorder version with similar symptoms.

The course and treatment for these disorders is usually dependent upon relationships with others. In treating these problems, a long-term relationship with a well-trained and specialized therapist is often necessary. It is also possible to work with parents and the entire family to alter the child's environment in a manner that alters the budding personality problem. However, such interventions require an understanding of developmental issues, the dynamics of personality issues, the psychological makeup of the parents, and the dynamics of the family. In working with Indian children, the therapists must also have an appreciation of the special characteristics of Indian extended families. For example, if the parents are unable to

institute the needed interventions, an uncle, aunt, or grandparent may be able to provide them, depending upon the extended family structure of the particular Indian culture. Recent work in several different areas of mental health strongly suggests that some types of personality disorders may have a genetic component. For example, in families of schizophrenics, patterns of schizotypal and schizoid personalities disorders are found that suggest they may be related to the genetic transmission of schizophrenia. It is not clear what approaches to treatment are needed in these cases.

Substance Abuse Problems

In both Indian and non-Indian cultures, the problems of substance abuse in young people appear to be increasing. Not only is alcohol abuse becoming a problem in younger children, a variety of other drugs and toxic substances are also being used and abused. In addition, the common drugs of abuse among children and adolescents appear to be increasingly dangerous and harmful. In addition to alcohol, other substances such as inhalants like gasoline and paint solvents are in common use among children on reservations, and drugs such as phencyclidine (PCP) present special dangers for permanent damage to the brains of children and adolescents.

The course of substance abuse disorders is quite variable. In some children and adolescents the problem resolves with increasing levels of maturation. In other cases, permanent damage results before the drugs or other substances are abandoned. In still other cases, early drug abuse patterns become consolidated into a life-long pattern of substance abuse that shortens the person's life, interferes with the person achieving his or her potential, and has a variety of other negative outcomes.

Effective treatment for these conditions is not at all proven. In selected cases, the child or adolescent may benefit from inpatient drug or alcohol treatment programs, from family therapy, or from treatment for other psychiatric disorders that may also be present. Peer group therapy is also effective in cases in which the child or adolescent is well "connected" to other children or adolescents in the peer group. It should be noted that because this group of problems is in the public view, there has arisen a large economic interest in programs for alcohol and drug abuse among children and adolescents. Although these programs are undoubtedly beneficial for selected children, the economic interests of these rapidly proliferating programs lead the prudent clinician to have some doubts about claims of miraculous results. There is a singular lack of data at present demonstrating statistically valid outcomes from the treatment provided by these programs.

As a matter of "common sense," prevention of alcohol and drug abuse among children and adolescents is the most logical way to attack this growing problem. A variety of approaches to prevention are currently being investigated. Caution is appropriate in attempting to devise and

implement prevention programs for alcohol and drug problems. Certain health education approaches are particularly suspect. Because of the known possibility of the paradoxical "backfiring" of these prevention programs, there is an urgent need to study outcome data from the specific programs prior to wholesale duplication.

An additional caution must be noted. Among adults, successful treatment for alcohol and drug abuse depends upon a variety of factors, including the socioeconomic class of the person and the person's cultural background. Certain approaches such as aversive conditioning have been shown to be effective with upper-middle class adults, but largely ineffective with lower socioeconomic groups. It would not be very surprising to learn that treatment and prevention approaches that are effective with middle-class non-Indian youth might not be effective for reservation Indian youth.

The current trend across the country in adult alcohol and drug treatment is to evaluate each individual patient/client and design an individualized treatment program for him or her. This individualized program is based upon a formal structured evaluation matching the characteristics of the patient to specific therapies found to be effective with specific sub-groups of alcohol and drug abusers. It would not be surprising to see alcoholism and drug treatment and prevention programs for adolescents follow similar trends in the next several years. For example, it may be found that high-achieving amphetamine abusers respond to educational efforts, while inhalant abusers respond to peer counseling.

Environmental Problems of Children

Although not internally based, a number of environmental problems are sufficiently likely to produce damage to a child to warrant special attention as disorders of childhood. Usually these problems are the result of actions of others, particularly significant adults. They may also be the result of environmental conditions such as foster homes or boarding schools. These environmental problems produce long-lasting psychological problems with a high degree of probability, and are clearly worth interventions by mental health programs. Interventions for all of the environmental problems of children are complex and may require that the mental health staff member become involved with the courts, the legal system, other health disciplines, and educators in addition to working with families. In perhaps no other area of mental health is the provider as likely to be assaulted, to be the subject of political attention, or to lose a job as the result of appropriate and ethical conduct. For this reason, environmental issues for children quickly become programmatic issues of therapy.

Child Abuse: It is not clear whether the incidence of child abuse in America in general and on reservations in specific is increasing or whether increasing awareness of this problem has caused greater concern and

increased reporting of incidents. As recently as 1980, articles about the mental health of Indian children stated that child abuse was uncommon among Indian people. However, within the last several years the reporting and awareness of child abuse has increased markedly.

Physical abuse of children and infants varies widely in severity. In extreme cases, children come to the attention of the health care system with burns over much of their bodies, with broken bones, or dead as a result of internal injuries, skull fractures, and other severe forms of abuse. In other cases, neglect may be so severe that the child dies of dehydration or infection. On the other hand, spankings and other forms of physical punishment may be acceptable in some cultures, and therefore cannot be considered abnormal in the context of that culture.

The role of the mental health staff person in these cases is as a member of an intervention team. In some cases, the treatable mental illness of a parent makes it possible to halt the abuse. In other cases of less severe abuse, the teaching of parenting skills may help the parent to avoid becoming so angry that he or she is likely to abuse the child. It is known that people have a tendency to learn parenting skills from their own parents. As a result, children raised apart from their parents in an institutional setting may lack parenting skills of either specific types or in general. It is speculated that some of the worst Indian boarding school experiences in the past may have deprived segments of the Indian community of parenting skills. Several techniques in replacing missing parenting skills may be helpful in treating and preventing child abuse, such as the use of elders or grandparents to recapture traditional parenting skills, or the teaching of parenting skills according to one of the standard parenting skills programs.

Foster care to intervene in child abuse, an option often preferred by the courts, is clearly not always the ideal solution for child abuse and neglect problems. As is the case with sexual abuse, abused children placed in foster homes run a greater-than-average risk for the abuse continuing in the foster home. There are a variety of reasons for this, but perhaps the most perplexing is the tendency of children to need attention--even negative attention--more than being able to tolerate neglect. As a result, children in abusive families tend to learn a pattern of precipitating the abuse as a means of getting at least some attention from others. For this reason, several model "therapeutic foster homes" with specially trained foster parents have been developed in Indian communities. The foster parents are trained to respond to the perplexing behaviors of these children in consistent, therapeutic ways. Therapeutic foster homes are expensive, however, and it is difficult to find potential foster parents who are willing to undergo the training and supervision necessary to help these children for the limited money that is available.

The solution to the problems of child abuse are still a long way from being found. The best that we can do for the moment is to consider that the problem of child abuse has many aspects, and of necessity involve the

skills and thoughts of the courts, the foster care system, mental health care providers, physical health care providers, administrators, and a host of others. It is both an internal psychological problem for the victim and the abuser and at the same time a problem of the social system and the cultures in which it exists.

Perhaps the most effective interventions for mental health programs in Indian communities at present are to work on building awareness of the problem of abuse in Indian communities, and to work as active contributors in the larger system of people attempting to help with this problem. In locations in which the system of people working with the problem of child abuse has not been organized, the mental health staff member can contribute significantly by helping to organize providers, legal people, and educators into teams. Other activities, such as encouraging Tribes to pass child abuse codes, can also help to advance the work on this problem.

Administrators can be helpful in working with child abuse by protecting their staff from the frequent community outrage that arises when this subject is discussed. This clinician recalls several incidents in which even talking about physical or sexual abuse was met with resolutions from the Tribal government to remove the staff member who had dared to broach the subject. In these cases, administrative interventions were required to save the job and position of the staff member.

<u>Sexual Abuse:</u> Following the increasing awareness of the physical abuse of children, there has come to be an increasing awareness and concern about the sexual abuse of children on reservations. Like physical abuse, the problem of sexual abuse has been present long before public awareness of the problem, and it is not possible to say whether such abuse is increasing or if we are just becoming aware of a problem that has existed for a long time. Perhaps because sexual abuse of children violates the taboos of many cultures, including the mainstream American culture, reactions to the subject tend to be extreme. The anger that sexual abuse arouses in the public tends to make all discussions of the subject very emotionally laden and may make public planning around the subject very difficult.

Sexual abuse affects children in many different ways. Issues such as whether the abuse is a repeated pattern or an isolated incident, the age of the child at the time of the abuse, whether the abuser was a trusted adult, a stranger, or a sibling, and the reactions of others in the child's network all contribute to the impact that sexual abuse has upon the child. In some cases, there is relatively little impact upon the child's development. In other cases, such as the repeated abuse of a late preschool child, the sexual abuse may be so involved with developmental issues that the child is likely to suffer significant long-term difficulties from it.

One of the more confusing elements to repeated long-term sexual abuse is the child's behavior may often become "sexualized." The child may become sexually seductive in the manner of the physically abused

child inviting punishment as a vehicle for attracting any attention from adults, or in the case of the sexually abused child, avoiding physical punishment. This tendency may lead uninformed adults to punish the child victim of abuse in the legal system or in other ways. Children who are the victims of repeated abuse tend to behave in age-inappropriate sexual ways in the schools and other environments. Sexual displays in school are usually a sign that a young child should be considered a possible abuse victim, yet school systems are not yet aware of this, and in many cases persist in punishing the child, thereby further confusing him or her instead of referring the child for therapy.

Studies of adult prostitutes reveals that many were "sexualized" early in life by repeated sexual abuse. Furthermore, it is increasingly well known that sexual abuse victims sometimes tend themselves to become sexual abusers in an increasingly complex pattern of cause and effect.

Treatment for sexual abuse victims is a new and specialized skill in mental health, using play therapy and other techniques to first assess and then treat associated problems. It should be an element of pride that some Indian communities are treating sexual abuse victims in very sophisticated and advanced ways in comparison to similar non-Indian rural communities.

Increasingly it is the experience of therapists in Indian mental health programs that adult women who were abused as children need and benefit from programs to help them deal with the abuse many years later. The number of Indian women with a history of sexual abuse that is revealed in therapy is strikingly high.

Treatment for sexual offenders is a controversial subject. Most experts agree that the legal system must be involved in the process of first stopping the offender from repeated offenses, and that for the offender to have any chance at treatment there must be either a confession registered in the court or a conviction. Without such a legal sanction, the experts in the field are in almost complete agreement that treatment is next to impossible.

Experts disagree on most other points concerning treatment of offenders. Some, who appear to work mainly with victims, tend to believe that no offenders can or should be treated, and that severe punishment through the legal system is the only answer to the problem. Other therapists who work with offender programs believe that there are several types and categories of severity of offenders who have different degrees of responsiveness to treatment.

Pedophiles are adults who show a habitual sexual preference for young children. By the time they come to the attention of the legal and treatment system, many of these offenders have abused several hundred children. Pedophiles generally do not consider their sexual preferences to be a real problem and are very difficult (some would say impossible) to treat even using the most modern behavioral treatment technology, such as aversive conditioning with the penile plethysmograph, etc. The results of

pharmacological treatments even as substantial as hormonal treatments have not been encouraging. Pedophiles are often problematic in their tendency to wish to work in jobs and volunteer activities in which they have contact with young people, such as scout leaders, foster parents, and similar trusted positions. Pedophiles may exhibit heterosexual, homosexual, or mixed preferences, and may or may not have sadistic tendencies.

Where the experts differ is in the prognosis for treatment of the less severe sexual offenders. When taken as a large group, treatment outcome statistics for sexual offenders are disappointing. Many experts feel, however, that some sexual offenders respond better to treatment than others. They would argue that a step-father who abuses a 16-year-old girl over a short period of time and who has no other history of sexual abuse has much better prognosis for treatment than the habitual pedophile with a preference for very young children. A number of programs treat this seemingly less severe group of offenders with a variety of techniques and claim that they are even able to keep the family together in some cases.

Because of the emotional impact of this subject, it is essential that the victim and the offender have different therapists. Good therapists for victims generally do not have the sympathy and empathy for offenders required to provide adequate therapy to offenders. Much confusion in the field has resulted from victims' therapists making claims about the therapy of offenders. In planning a system for intervention in the sexual abuse of children, the administrator is wise to consider the position of the person making assertions about therapeutic outcomes, and to view the literature with an objective and critical eye.

Child Neglect: Child neglect carries a variety of consequences depending upon the type of neglect, its duration, and other factors. Unlike the various kinds of abuse, neglect has long been recognized to be a problem in various Indian communities. The outcomes of neglect are fairly well known, from the physical damage associated with inadequate care to the profound psychological consequences associated with early neglect.

The causes of child neglect are equally well known, ranging from parent's psychosis or severe depression to chronic alcoholism or drug abuse. Getting the potentially salvageable parent into treatment is not always an easy matter, however. The courts do not often use expert witnesses to evaluate parents who have neglected a child for conditions that can be easily treated. Instead, many courts tend to adopt unquestioningly the recommendations of child welfare workers who suggest placement of the child in a foster family without adequate mental health evaluation of the parent.

Substantial problems have arisen when courts in non-Indian environments place Indian children in non-Indian foster homes. This practice was the cause for passage of the Indian Child Welfare Act, which gives automatic jurisdiction for child placement to Indian tribes of which the child is a member. Across the country, however, there continue to be

problems with the courts in the states being unaware of the law and continuing in this illegal practice. There is increasing evidence that Indian children have severe identity problems and resulting behavioral difficulties in their teen-age years when raised by non-Indian foster parents. In recent years, internal policy of the BIA has diverted funds away from Indian Child Welfare Act programs, making many of these tribal programs ineffective.

It is the intent of the Act that the extended family of the Indian child be used as a placement alternative for Indian children over the use of foster homes. This is often quite successful as a means of placing the child in a caring Indian family. One risk for the child's development is when the child is passed too quickly at too early an age among family members so that bonding is never able to solidify. The use of trained mental health staff in working with extended families to provide help in rearing the child is an issue that has not yet been sufficiently explored by the IHS and Tribal mental health programs.

Another promising trend in several parts of the country is the use of special workers to help young mothers bond with their babies. This is explored above.

Adaptive Problems of Special Environments: Indian children are often placed by the courts in environments other than their homes. While these environments are by no means all completely harmful, there are often special problems attendant upon the nature of each. The Indian boarding schools of the past to which very young children were sent produced severe problems for both the children and their communities. Young children were separated from their parents at critical times in their development. One can imagine the impact of the loss of contact with the elders for much of these periods, and the resulting loss of much of the oral history and cultural traditions of some communities. Many of the children who attended these boarding schools of the past grew up as healthy, sane adults, which testifies to the power of peer groups and the efforts of good and stable adults who were able to help these children when they were far away from home and family. On the other hand, stories of abuse and poor treatment in the boarding schools are still common in most tribes.

Children in foster care perhaps suffer to a greater extent than even children in the boarding schools, according to many reports. There is often less opportunity to form stable relationships with others than in boarding schools. In addition, the frightening reports of the incidence of abuse, neglect, and sexual abuse in foster care sometimes makes one wonder why the courts seem to have such a strong tendency to place children in such care. This, of course, does not imply that all foster homes are bad. In fact, the majority are probably operated by healthy and charitable adults. However, when a foster home is damaging to a child, the impact can be so substantial that there is a deep sense of the wrongness of poorly supervised foster home systems in general.

Another special adaptive problem for Indian adolescents and young adults is the university environment. Increasing attention has been paid to

Indian students with good high school records and good intelligence going to college and experiencing very poor performance in spite of all reasonable expectations to the contrary. Without more information and further study, it is difficult to speculate on the causes and treatment of this phenomenon. Studies are underway to begin to understand the causes of this problem, with hope that they will lead to some possible solutions.

Problems of Adolescence

Adolescence is a problematic and poorly understood time, particularly for Indian people. Among many tribes and as in the general population, it represents a time of the greatest risk of psychological problems with serious consequences, including serious drug and alcohol problems, death by suicide or violence, legal problems, and a variety of other negative outcomes. As poorly understood as adolescence is in general, it is perhaps the least understood phase of the life of an Indian person, and also the phase most in need of understanding.

Suicide among adolescents is a problem of growing public awareness, yet the problem of suicide among Indian adolescents in some parts of the country is much more severe than for non-Indians. For non-Indians, suicide risk increases with age, in general, with a small increase in adolescence. For Indian people, the risk for death by suicide is far worse in the late teens and early twenties than for the rest of the person's life. In some Indian communities the risk of a young man dying by suicide is between 20 and 50 times that for a non-Indian male of the same age. The risk of death by traffic accidents is also correlated with mental health problems, particularly single-car accidents. The rates of death from accidents are very high for young Indian men and is extremely high on a number of reservations, including deaths from single car accidents.

Some mental health problems of Indians start in early adolescence. In several studies, Indian children began school at or above the achievement level of non-Indian students, testifying to the basic intelligence and ability of these students. However, the Indian children begin to slip in achievement until about the sixth grade their performance falls below non-Indian children; from there, it continues to deteriorate even further, usually culminating in early dropout from school. This phenomenon, known as the "crossover effect," is another testimony to the special problems of Indian children and adolescents.

There are probably a number of reasons for the problems of Indian adolescents. In part, there may be a holdover from the high rates of mental health problems in childhood. Depression and other mental health problems may develop in adolescents without the antecedent problems, or may be a continuation of a process which began in childhood. But many problems must be considered to be a unique response to the particular development during the adolescent years by Indians.

Eric Erickson's developmental system suggest one view of the developmental issues of adolescence. Just as the problem of the elementary school years is formulated in Ericson's model as "industry verses inferiority," the adolescent years are considered to revolve around the issue of identity verses "identity diffusion." Like the period from 18 months to three years when the toddler must establish a separate identity from the parents in the process of separation and individuation, the teenager must face the completion of this task and consolidate an identity independent from parents.

The question of what constitutes a "normal" adolescence has recently come into question. The process of adolescent rebellion which has been till now considered to be a part of adolescence is absent in other cultures. It is theorized that "normal" adolescent rebellion is a reaction to the highly controlling nature of mainstream American and European cultures with respect to the actual needs of adolescence. In cultures that do not place such a high degree of emphasis on control of children, this "normal" rebellion does not occur.

Why the Indian adolescent period with its issues of identity verses identity diffusion should be such a high-risk and dangerous period for the psychological well being of Indian youth is not known. Some have speculated that the lack of viable adult identities for Indian adolescents from tribes experiencing extreme cultural stress may be a contributing factor. Others speculate that the reasons for the problems of Indian adolescence is frank racism in schools and other environments with which the children have contact, particularly at the time at which the identity issues of the adolescent are paramount. If the adolescent receives strong negative messages from the environment, a very negative self concept may be adopted. In yet another explanatory system, the reason for these identity problems relates to other social problems in the communities. All these reasons are speculative at best. It will likely be years before a good explanation is found and workable solutions developed.

Disorders of the adolescent years are related both to disorders of adults and of children. Even though the mental health problems of this age group are related to those of other ages, and may even have identical mechanisms of illness, the way these disorders present is often unique. The role of the peer group is perhaps more critical to the mental health of the adolescent than are institutions such as schools.

Mental health staff have a number of definite roles in the care for the mental health of adolescents. In addition to treating major mental illness, it may be appropriate for mental health professionals to provide a variety of more routine services ranging from promoting good mental health to helping families cope with this tempestuous period. However, with adolescents perhaps more than any other age or patient group, the unique characteristics of the therapist may be critical to the success or failure of the intervention program. It is a matter of the lore of mental health that good

therapists for adolescents may not be the same people who are the best therapists for adults or children.

In the multitude of functions that mental health programs provide with respect to the mental health of adolescents, many require the same skills that allow the therapists to treat major mental health problems of adults. These adult therapy skills will allow the therapist to do an adequate job, but he or she may not be able to maintain the long-term relationship needed for working with personality problems of adolescents.

Some of the other disorders with unique features in adolescence are detailed below.

"Normal" Problems of Adolescence

As noted above, many of the difficulties encountered in the process of adolescence may be artifacts of the general American culture, which places a high value upon control of young people. In young Indian people, developmental tasks are complicated by discrepant expectations placed upon the Indian adolescents by the cultures of which they are members. For reasons frankly related to racial prejudice, Indian adolescents may have higher expectations for conformity and control in the schools and from non-Indian law enforcement agencies than their non-Indian counterparts. At the same time, in a number of traditional Indian cultures the control of the adolescent is not highly valued; as a result, the young person may live in a very confusing world, indeed. At school, there may be high expectations for conforming to rules and regulations, while expectations at home are for good behavior but without what must seem the microscopic, even ill intentioned scrutiny from the non-Indian world. Would it be any wonder if these young people had some identity problems in such an environment, or if they dropped out of the relatively structured environment of school?

The role of the therapist in such settings is to help the adolescent find an understanding person who can help devise strategies to cope with confusing situations. In the face of a strange adult world, the peer group becomes critical in the lives of most adolescents. Depending upon the composition of the peer group, the adolescent may be lead into either valuable or harmful experiences, such as alcohol or drug abuse, or even group suicides. If the peer group is basically healthy, the therapist's job is to help the adolescent find acceptance and membership in the group. If, on the other hand, the peer group is unhealthy, the therapist has the responsibility of helping the adolescent sort through his or her need for acceptance verses his or her own values and the values of the family. In cases in which parents are keeping too close control over the adolescent, the role of the therapist is to help the adolescent to separate as gracefully as possible from intense control into a more realistic relationship with parents. As is the case with many areas of Indian mental health, little formal research has been performed with Indian adolescents and their families in

order to define norms for this population and methods of working with Indian adolescents when the adolescent varies from the norm.

Substance Abuse Disorders

Substance abuse among adolescents has been a problem for at least the last 20 years. Among non-Indians, the drug abuse of the 1960s and early 1970s involved mainly hallucinogens and marijuana. It is likely that the abuse of alcohol long antedated the drug abuse patterns of the 1960s, and continues today. Alcohol may still be the most damaging drug of the adolescent years for producing physical damage to the brains and organ systems of young people. However, in the non-Indian American culture, the 1980s have brought new patterns of drug abuse among adolescents that may even be more troubling than the problems of a decade or more ago.

In America, the increasing use of psychomotor stimulants such as cocaine and amphetamines and the abuse of prescription medications produces far more potential damage to the young person than the hallucinogens of the past. The role of the psychomotor stimulants in producing psychotic conditions and organic mental syndromes is of concern, even though these syndromes may clear with abstinence. More troubling is the possibility that many of the long-term schizophreniform psychoses of adolescents may be precipitated by the psychomotor stimulants. Because prospective studies are obviously impossible for ethical reasons, no one yet knows if the amphetamines and other psychomotor stimulants can precipitate permanent psychoses, or if "pre-psychotic" young people also tend to use these drugs as part of the onset of schizophreniform disorders. From animal studies, many neurobiologists believe that these substances can "kindle" psychotic processes in the brain in an animal that would not otherwise be psychotic. However, it is impossible to tell from only behavioral observation if the picture of unusual behavior in rats is the same symptom pattern as the psychoses in humans.

Although the intravenous use of amphetamines appears to have declined, a new and very dangerous form of cocaine known as "crack" has come into the communities. This is an extract of cocaine that is very pure and is meant to be smoked. Prices for a dose of crack are sufficiently low that dealers can sell single doses to children and adolescents at prices they can afford. "Crack" is reputed to be much more habituating than powdered cocaine.

Another new and highly dangerous trend is the use of "designer" drugs. These drugs represent a problematic new area in that they cannot be well regulated under law. Designer drugs are similar to old drugs whose chemical structure has been altered so that they no longer are the same as drugs regulated by the DEA. They may also be much more dangerous than the old drugs. For example, one batch of a drug which resembles known

synthetic narcotics was found to destroy dopamine receptors in the brain, producing from just one dose a permanent condition resembling Parkinson's disease. Others of these new drugs pose similar dangers, and though they are called "designer" drugs, they are sometimes available to adolescent Indians.

Of even greater concern is the use of phencyclidine, also know as PCP, "angel dust," "dust," "hog," etc. The ability of this substance to produce permanent changes in the brain has long been suspected. In addition, this substance (which was invented as an animal tranquilizer related to the drug ketamine) produces a very unusual psychotic state in which the person does not feel any connection with sensations of pain in his or her body, yet retains physical control over muscles. PCP produces severe delusional and hallucinatory states, and the combination of effects produces a condition of a psychotic, strong, and violent person who is immune to pain. Many severe and violent crimes are associated with this drug, and police who have experience with it are unwilling to try to restrain a "duster" without at least four officers. This drug is sold as "acid," even though it is a far different drug than the relatively less harmful true hallucinogens, such as LSD. (There are few true hallucinogens sold on the streets these days because PCP is easy to make in the underground labs, and the chemicals needed for the synthesis are cheaper to buy and not as easily traceable as those needed for LSD synthesis.) Overdose of PCP is a dangerous medical condition that is very difficult to manage due to the cardiac instability in a violent patient. Because of the dangers of these patients to staff and to other patients, and the possibility that drugs such as the major tranquilizers can kill PCP-overdosed patients, they should always be managed in a secure inpatient setting by a team that includes an internist and a psychiatrist.

Other grave dangers are represented by modern drug abuse trends. The narcotics, both synthetic and "natural," are in increasing use in many communities. Similarly, the sedative-hypnotics have been popular drugs of abuse for a long time. Risks from both of these groups of drugs include the danger of death from respiratory depression. Brain function may become so depressed that the respiratory centers are shut off. In many ways the sedative-hypnotics are more dangerous than the narcotics, in that the withdrawal syndromes from the narcotics, while unpleasant, are not fatal. Poorly managed withdrawal from the sedative-hypnotics can be fatal to the patient because of seizures and other problems.

Marijuana is increasingly recognized to have long-term consequences for certain aspects of intellectual functioning. It cannot reasonably be considered a "benign" drug even though the health risks are far less than those of the stimulants or PCP. Marijuana appears to be very common on reservations, though few treatment programs deal with its use.

No one really knows the extent of national or regional drug abuse among Indian adolescents. The author has seen virtually all of the major classes and drugs of abuse used on reservations. A demonstration

program for one Plains reservation targeted narcotics abuse along with other drugs of abuse. In spite of everyone's expectations (including myself as one of the writers of the grant proposal) that there might be a moderate number of narcotics users, the program was rapidly overwhelmed with of patients referred to the program for treatment. After just a few months of operation, there was a waiting list of several months for admission into this exclusively outpatient program.

Other drugs are also used widely, but rarely recognized on reservations. This clinician has seen many patients on reservations referred for "schizophrenia" that demonstrate classical drug toxicity symptoms, and who later admit that they were using "acid" or amphetamines.

In addition, reservations may have some unique drug abuse problems. On some reservations in the West, there are populations of solvent abusers, who abuse substances such as paint solvent (particularly from aerosol metallic paints), gasoline, and other substances in preference to alcohol and marijuana. Solvent abuse may have serious consequences ranging from lead poisoning to liver damage and even cancer from chronic exposure to toluene, a known carcinogen. A few programs, such as the Ft. Hall Reservation in Idaho, have developed special expertise in solvent abuse treatment, but remain pessimistic about successful treatment outcome and prognosis.

It is difficult to say whether the abuse of drugs or alcohol is the more significant problem among adolescents on the nation's Indian reservations. Among Indian adolescents, little is known about either pattern of abuse. For a number of reasons, users of traditional alcohol programs on reservations tend to be more the chronic alcohol abusers. Many of these programs do not serve other drug abusers. Adolescents appear to have much less contact with existing alcoholism programs treatment on reservations, perhaps because they have other major patterns of drug abuse than just alcoholism.

At the moment, what appears to be a massive drug abuse problem on the nation's reservations remain unaddressed. In part, this may be an artifact of funding and staffing patterns of Indian treatment programs, with most of the money that could potentially be used for such projects being funneled through the alcohol program system into programs that were designed exclusively for alcoholism treatment. Likewise, mental health programs have few staff who have knowledge or expertise in drug abuse treatment for adults. IHS physicians and others in the health care system have little exposure to the specialized skills needed for the acute treatment and detoxification of drug abusing patients in a general residency. Money channeled to reservations for drug abuse treatment beginning in 1987 has resulted in little published positive outcome in the literature.

One note of caution may be in order. Although the prevention of alcoholism and drug abuse among children and adolescents is clearly a better idea than waiting for drug abuse to develop and then treating the

consequences, there has yet to emerge a provable effective mechanism for preventing drug abuse among Indian adolescents. In fact, evidence from more than a decade ago demonstrates that certain "educational" approaches that try to frighten adolescents away from drug use actually increase the use of drugs in the adolescent population. For this reason, extreme care must be exercised before planning prevention programs that may actually make the problem worse.

Affective/Psychotic Disorders

Unlike the adult population in which affective and schizophrenic disorders are usually clearly distinguished from each other, these disorders may present in a disorganized, psychotic-appearing fashion among adolescents. Mania and schizophrenia among adolescents are often particularly difficult to differentiate. For a variety of reasons, psychotic disorders that appear in adolescence have a bleaker outlook than the same disorders presenting in an older individual. Schizophrenia in teenagers tends to carry a less favorable outcome than schizophrenia which appears later in life, and to be a more severe than when this disorder develops in the late twenties or thirties.

Depression may present differently in teenagers, as well. It appears that adolescents may have a somewhat different pattern of symptoms than adults from what is assumed to be the same biological depressive process in the brain. For example, adolescents who are depressed tend to sleep more than usual and eat to excess, unlike adults who tend to have insomnia problems and to have a loss of appetite and interest in food. Although pharmacologic treatment for adolescents is similar to adults, the strategies of psychotherapy may need to be very different. In comparison to adults, there is less treatment outcome data for adolescents. As a result, much more depends upon the unique but difficult-to-define skills and supervised, specialized training of that clinician.

Adolescents tend not to fare well in inpatient programs designed for adults. In fact, an adult psychiatric unit with severely disturbed adults may be a nightmare for a teenager. It is speculated that the ability of the adolescent to live outside the institutional setting in the future may be damaged by long confinement in settings such as old-style state hospitals. For this reason, special adolescent inpatient treatment facilities are mandatory. In the West, however, there is a very serious shortage of such facilities, and those that do exist tend to have long waiting lists. This is doubly a problem for Indian adolescents who may have to cross two or three states to reach the nearest such facility, and who may be unable to get this treatment paid for by IHS in the face of decreasing contract health care funds. Within the IHS, care for these adolescents has been given low priority by a contract medical care system that for understandable reasons is forced to prioritize emergency surgical services before the inpatient mental health care for the adolescent.

In extreme cases, mental health care for adolescents suffering from major mental illnesses can be "patched together" by treatment staffs working in the community. Existing residential facilities, including motels, have been used for this purpose, with visits from doctors and constant observation and supervision from a mental health staff person. However, this requires a high level of training on the part of the mental health staff and physicians, and should be considered as a secondary alternative at best. General medical beds have been used for acutely psychotic adolescents, but many times these patients pose a sufficient danger to untrained staff and other patients that such an approach should be considered as a worse alternative than the use of a motel, and should be used only in extreme conditions. Other alternatives hold some promise, but have yet to be tried in Indian communities, such as the use of intensive foster care in homes or other residential treatment alternatives.

If experiences with adult Indian people hold true for adolescents, there is also reason to believe that diagnostic criteria for some of these disorders will not be the same for Indian adolescents as for non-Indians. This would necessitate the development of new diagnostic instruments for use with Indian adolescents in order to diagnose major affective and psychotic illnesses.

Other Disorders of Adolescents

Most of the disorders present in adults are also present in adolescents, although the symptoms may differ significantly from those of adults. Phobias, organic mental syndromes, obsessive-compulsive disorder, and other disorders look similar enough to the same disorders in adulthood that the well-trained adult therapist can make a reasonable attempt to provide care for them. A mental health professional with special experience and training in adolescent mental health may, however, be somewhat more effective and certainly more efficient in sorting out these complex presentations and providing the most effective treatment.

Other disorders more unique to the adolescent require a special set of therapeutic skills. For example, identity issues of adolescence are most appropriately dealt with by a therapist with the training and innate skill to work best with them. These identity issues can produce massive discomfort for the adolescent, and may produce a variety of symptoms ranging from anxiety and dysphoria (the sad feelings that the general public means by the term "depression") to major depression, drug abuse, legal difficulties, and a host of other problems. Identity disorders commonly cover a multitude of issues ranging from sexual identity to a recapitulation of earlier issues of autonomy, industry, initiative, and basic trust. The degree of identification with a peer group is also a common problem. Identity disorders are one of the known risk factors for suicide among adolescents.

In addition to identity problems, adolescents often suffer problems of adjustment to strange or changing situations. The transitions of the

adolescent years place stresses on the adolescent that they are perhaps less well equipped to handle than at other times in their lives. This is due to the changes in their internal states such as having to deal with identity issues and physical changes at the same time as they have to deal with rapid changes in the environment. Difficulties in changing peer groups, in successes and failures in school and relationships, in encounters with the legal system, and in changes in the family unit (such as parental separations) all create environmental stressors for the adolescent that may produce a variety of symptoms. One of the skills of the therapist is to help the teenager resolve these adjustment disorders with a minimum of pain and lasting damage.

Because of IHS operations associated with the boarding schools and for other reasons as well, the IHS and tribal programs seem to be blessed with a number of therapists who have the natural inclinations and instincts to be adolescent therapists. There appear to be a greater number of therapists with the interest and skill in the treatment of adolescents than in the treatment of smaller children. However, the major problem in creating treatment programs for Indian adolescents is the lack of formal training for therapists who have the interest and innate skill to work with adolescents. There is a need to develop these natural therapists with the didactic training and ongoing supervised therapy instruction that they need to become effective adolescent therapists.

Recent interest in child and adolescent mental health in the IHS suggests that there may be hope for this underserved population. However, the IHS also has major needs for a spectrum of services for adolescents from structured residential programs to half-way houses in the community. Few of these programs now exist. A true treatment system for adolescents in Indian country may be years--if not decades--away from reality.

Disorders of the Elderly

In contrast to the Indian adolescent, evidence suggests that Indian elderly may do better in general than their non-Indian counterparts. It is the impression of those working in the field that elderly Indian people are far less likely to be forgotten, neglected, or ignored than the non-Indian elderly in America. Because there are major mental illnesses in the elderly as well as in younger people, Indian elderly suffer from depression, from panic disorder, and mental health problems that they have had all their lives as well as facing new disorders. However, in many Indian communities, the valued place of the elder in the community may make such illnesses easier to cope with, and may reduce the duration of episodes of illness in addition to reducing the number of crises.

There are a variety of disorders and presentations of disorders among elderly Indians that are unique, however. Many of these disorders, with a basis of disturbance of functioning of the brain, occur independently of the person's culture and affect Indian elderly as well as non-Indian elderly.

Perhaps because of the characteristic altruism of the elders who are in planning positions, the IHS and many tribal programs consciously place a low priority on the problems of the elderly in favor of prevention efforts directed at youth. At one point, placing a low priority on health problems of Indian elderly was a stated policy of the IHS. While putting the needs of elders after those of younger people (understandable in light of the limited resources available), it must be pointed out that mental health services for the elderly are often highly effective and produce many benefits for Indian communities. In the first place, many of the mental health problems of the elderly are easily amenable to inexpensive treatment that can definitively improve their quality of life. In the second place, the elderly have so much to contribute to the lives of the young that the loss of the life or function of an elder is a major loss to the entire community. Third, competent mental health services for the elderly save money for the community and the health system. For example, adequate treatment of some of the problems listed below can make the difference between costly care in a nursing home or continuation of a functional life in the home of the family.

The skills needed to work with the elderly are, like the special skills needed to work with children and adolescents, not often taught to mental health workers in many disciplines. The new fields of geriatrics and gerontology train people with adult therapy skills to work with elders. With very few exceptions, the IHS is lacking in these specially trained workers. It is possible to train a geriatric team of mental health workers, physicians, social workers, pharmacists, and others to be an effective intervention tool, with even minimal training resources, however.

Organic Mental Disorders in the Elderly

Organic mental disorders in the general patient group have been discussed above. In the elderly, organic disorders assume special significance. Of all the mental disorders likely to put an elderly person into a nursing home, organic mental disorders and the conditions which mimic them are clearly the most significant group. Once in the nursing home, the elderly person's survival rates decrease significantly. The irony is that most studies on the subject show that over half of the organic mental conditions labeled as "senility" and written off as hopeless can be cured or significantly improved with adequate diagnosis and treatment. Furthermore, other studies demonstrate that even at major teaching hospitals, general physicians are unable to recognize treatable causes of mental disorders in about three fourths of the cases. The loss of function and the expense arising from the lack of good mental health work with the elderly must certainly be very substantial in both Indian and non-Indian communities.

Organic mental syndromes in the elderly fall into a number of categories. The short-term "delirium" state may be caused by any acute insult to brain functioning. Often this is caused by an infection, a toxic or

metabolic problem of an acute nature, or by traumatic brain injuries. Usually physicians and mental health staff realize that something of a neurological nature is going on and undertake a neurological examination. Often these conditions demonstrate only signs of problems of the frontal cortex such as snout, suck, grasp, palmomental reflexes, and other neurological "soft signs." In some cases the physician may not look for these unusual findings and may assume that the elderly person has a "schizophrenic break." (Schizophrenia very rarely begins after age 35, a fact which should but does not always cause physicians to be skeptical of any diagnosis of later onset schizophrenia.) In some of these cases, the elderly person may not get the needed evaluation and may be inappropriately placed on neuroleptic medication. In the worst case, the cause of the delirious state may be missed and the patient dies. This is fortunately relatively rare.

Much more common are errors made in the diagnosis and treatment of what appear to be dementias in the elderly. Dementias and dementia-look-alike conditions appear slowly and get worse over a period of weeks or even months. True dementias are irreversible and arise from a number of causes. The most common of these dementing conditions is Alzheimer's Disease, a progressive disorder involving slow but irreversible deterioration of the brain. The cure for this disorder is the subject of a great deal of active current research. A number of other conditions produce a chronic deteriorating course. It is suspected that a number of these diseases may be caused by "slow viruses" or by metabolic factors. Other chronic deteriorating conditions among the elderly as well as the younger patient may be caused by infectious agents, such as syphilis or the HIV (AIDS) virus. Tumors such as meningiomas may also produce a chronic deteriorating condition resembling a dementia. A number of other conditions cause a sudden loss of brain functioning, following which there may be a stable or even a slightly improving course. Strokes and other one-time brain injuries are included in this category.

A wide variety of conditions among the elderly lead to conditions that appear to be dementia, but which are easily reversible if the clinician knows how to approach the evaluation of the patient. One of the most common causes of these conditions is the response of the elderly to particular medications. Older people metabolize and excrete drugs at a much slower rate than younger people. In addition, the elderly person may be taking a wide variety of medications for a number of chronic medical conditions; these medications may interact with each other and change each other's levels, cause each other to be excreted or metabolized at an unusual rate, or have additive side effects. In addition, certain medications have a profound effect on the brain function of certain elderly people. Many examples of the kinds of organic mental syndromes that the elderly develop in response to medications come to mind, but the most common medications that are found among supposedly demented elderly are heart medications such as digitalis (at toxic blood levels), antihypertensives such as reserpine or propranolol, anticholinergic medications whose side effects

are additive, and drugs like Dalmane, whose metabolites build to toxic levels in the blood of older people over a course of weeks.

Metabolic and endocrine (hormonal) conditions also lead to organic mental syndromes in the elderly. Common offenders include hypothyroidism, electrolyte disturbances (particularly those involving potassium and calcium), and steroid-induced psychotic organic mental syndromes. Vascular conditions may or may not be reversible depending upon the type of problem, but a slow bleeding between the brain coverings and the skull, known as a chronic subdural hematoma, is found in the elderly and is often missed because of its slow onset and the lack of history of trauma to the head. In some cases the bleeding is in the frontal area of the brain and is missed because the frontal signs are not elicited on neurological examination. Relatively benign tumors of the brain and brain coverings may also be missed if they occur in a "silent" area of the brain. Autoimmune diseases can also present with organic mental syndrome symptoms.

The roles of the staff members on the geriatrics team must be to bring each of their unique skills to bear on the diagnosis of organic mental syndromes before any treatment of pharmacologic management strategies are casually undertaken. The mental health staff member, with appropriate training, can use the mental status examination to determine if an organic mental syndrome is present, or if the condition has affective, psychotic, or personality features as a valuable clue to the cause of the organic mental syndrome. The role of the physician must be to perform a good neurological examination of these patients, and if it is determined that an organic mental syndrome exists, to perform the medical tests required for the diagnosis of the underlying medical condition. Pharmacists can be very useful in reviewing patients charts for possible drug interactions and similar problems.

For either the true dementias or conditions that may mimic them, the family (or couple of which the patient is a member) is likely to need a significant amount of help if the patient is to remain in the home. Community health nurses have a variety of skills that are particularly useful in this respect. Likewise, community health representatives and other providers may have unique skills that can be brought to bear. Social service workers may be particularly valuable in finding resources for the patient to get needed care in the home, or in helping the family cope with nursing home placement, if this is required.

<u>"Pseudodementia"</u>

Although there are a number of conditions which resemble dementia, the term "pseudodementia" has come to refer to depressive illness in the elderly that resembles dementia. Pseudodementias may resemble dementia so closely that even a well-trained general mental health worker, using a good mental status examination, may be unable to tell that the patient is suffering from depression rather than dementia. In cases of

severe depression in the elderly, the person's thinking may become markedly disturbed, and the mental status examination may yield results that closely resemble an organic mental syndrome. The elderly person's temper may become very short, as in dementia, and the patient may not complain of a depressed mood. In severe cases, patients may develop delusional beliefs to such a degree that they believe themselves to be completely bad or unworthy of any help. One clue to the diagnosis of depressive pseudodementia may be a major weight loss, although cancer and several other medical conditions also produce unexplained weight losses.

Treatment for depressive pseudodementia is the treatment of the depression. In older people, the treatment of depression is more complicated than for younger patients, but is likely to be effective. Side effects of the older, cheaper antidepressants are often dangerous because in the elderly they may produce certain types of heart block, urinary retention, anticholinergic delirium, and a variety of other problems. Older peoples' metabolism necessitates doses of medications that are very small in comparison with the average adult dose. As a result, the newer antidepressants with fewer side effects are clearly the treatment of choice for depression in older people. There are many experienced clinicians who feel that electroconvulsive therapy is the clear treatment of choice for elderly depressed patients, particularly for those with known heart conditions, because of its safety to the heart. Even though this treatment may be the safest, the political sensitivity of electroconvulsive treatment makes it impractical for the IHS to consider.

With effective treatment, elderly persons with pseudodementia may have an almost miraculous return to functioning. The person who was thought to need a nursing home may be able to return to the family with many years of productive life left. This is one of the reasons that specialized mental health workers who have had specific training in mental health work with the elderly find this work exciting and fulfilling. The impact of treatment of depression in the elderly and its effectiveness are a reason for IHS to consider better funding for mental health services for the elderly.

Sensory Deprivation

Another of the disorders that can mimic psychotic conditions among the elderly occurs when the older person loses contact with the environment. This may be the result of loss of sensory function such as increasing deafness or visual trouble, or a loss of sensory stimulation from being placed in an environment with limited sensory input, such as the intensive care unit of a hospital. Although the causes are different, results of sensory deprivation are much like those of sensory deprivation tank experiments. Such deprivation may result in confusion, psychotic symptoms, and depression. In some cases, the function of the mental health staff member is to work with a team of optometrists,

ophthalmologists, audiologists, neurologists, and others to attempt to restore the elderly person's sensory input and thereby his or her mental health. In other cases, mental health or social service staff can help to restructure the patient's social and physical environment to provide other forms of sensory input, and help to provide other links with reality, such as ongoing social contacts with friends and family. In the hospital and nursing home, mental health staff have a customary function of trying to increase the sensory richness of the environment by means such as putting clocks and calendars in rooms, convincing administration to put chronic patients into rooms with windows, turning lights on and off in a day/night cycle, convincing staff to introduce themselves each time they enter the patient's room, and a variety of interventions that have become well known on inpatient wards. These interventions are also appropriate at times in a patient's home.

Adjustment Problems of the Elderly

The elderly suffer from a variety of difficulties related to social and environmental problems. They may have experienced relocation from their homes of many years into nursing homes or other living situations. They experience grief from the loss of friends, spouses, and family members. The death of a spouse is particularly devastating (more so for older men that women, according to statistical outcome studies). These situational changes produce a risk of death for the elderly at a higher-than-expected rate. The role of the mental health and social service staff is to help elderly people cope with these changes. Effective interventions following major losses for the elderly can be very valuable in helping to prolong the person's life. In addition, treatment for depression and other mental health conditions can significantly prolong survival. Because elderly Indian people are thought to have better support networks than non-Indians, there may be somewhat less need for helping them cope with adjustment reactions than in elderly non-Indian Americans. In many cases, the social systems of the reservation and extended families may help the elderly Indian person adjust to losses very effectively. In other cases, mental health interventions are clearly indicated.

Other Mental Health Problems of the Elderly

A number of other conditions are unique to the elderly. A condition that is well recognized among British psychiatrists, and is certainly found in America as well, is known as late paraphrenia. This is a condition that usually affects women from their fifties to their seventies, and includes delusional and hallucinatory symptoms. The delusions are often persecutory and sexual in nature, and are accompanied by hallucinations of a tactile nature. The typical patient lives alone and develops the symptoms without an earlier life history of psychotic symptoms, but with a

history of being "unusual." Most psychiatrists familiar with this disorder are convinced that it is a different disease entity than schizophrenia, even though the symptoms are superficially similar and the medications that are used to treat it are those that also work for the treatment of schizophrenia. This clinician has never seen a case of late paraphrenia among Indian people, and there has never been a report of this condition among Indians. Nevertheless, the lack of such reports has little significance because many conditions that have never been reported in Indian health systems are found shortly after clinicians are trained to look for them.

A number of conditions that had been present throughout the person's life are also present when the person enters old age. In the case of personality characteristics, a mild organic mental syndrome may precipitate exaggeration of personality characteristics that had been only mildly abrasive in earlier life. Some clinicians argue that some of the elderly may have abrasive personality characteristics precipitated by environmental conditions even without organic mental syndromes. Contrary to common opinion, psychotherapy for elderly people, (even with a focus on producing help with personality issues) may be helpful and productive according to clinicians familiar with work with the elderly.

Special Conditions

Mental health technology has developed special approaches to a number of populations and groups. These groups experience unique problems, and unique approaches to their treatment have proven effective. The problems of post-traumatic stress disorder among Viet Nam veterans have been publicized in recent years; the Veterans Administration (VA) admits that Indian veterans have not utilized the VA programs for this disorder. It was thought for a number of years that Indian Viet Nam veterans did not suffer from the same difficulties as non-Indians. However, this supposition is not borne out by the experience of Indian mental health clinicians. Indian Viet Nam veterans suffer from many of the same problems as non-Indians but may not have access to or do not chose to use VA programs. Indian veterans frequently observe that they do not have access to urban VA programs. In response, several clinicians from the IHS and tribal mental health programs have devised their own programs for Indian veterans, with surprisingly high levels of participation and support from Indian Viet Nam veterans.

Another special population whose needs are being addressed through a number of special programs are adult victims of sexual abuse. Many of the participants are women, often in their twenties and thirties, and sometimes older. The long-term damage felt by these people has been found to be helped by sharing with other victims in groups. These support and therapy groups are a growing movement in Indian as well as non-Indian mental health programs and communities.

Several innovative approaches have been developed for problems of children and adolescents. One innovative program on a reservation with high levels of child neglect teaches homeless children survival skills needed for life on the streets and on their own. The same reservation has developed therapeutic basketball team for boys with absent or alcoholic fathers. In several locations, special programs have been devised for people with mixed alcohol and mental health problems.

The modern trends in mental health demonstrate that programs designed for these and other special populations are cost-effective, produce substantial benefits from limited funds, and develop resources within the community. The disadvantage of these programs is that they may cause a loss of focus on other, even more serious problems within the service population.