

PSYCHIATRIC FUNCTION AND ROLES IN AN INDIAN HEALTH PROGRAM CONTEXT

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Abstract: This paper relates the experience of a non-Indian psychiatrist who successfully functioned in an urban Indian health care setting. It illustrates the process of becoming a part of a mental health team and the complexities of becoming a culturally-sensitive psychotherapist. This is accomplished by relating personal experiences, observations, case examples and self-questioning of therapeutic roles and functions. The author concludes that a psychiatrist should not rigidly define his or her role upon entering a particular setting but instead should allow a multitude of roles to unfold. Psychiatrists are also urged to remain constant students of the culture of the patients and organization, applying that knowledge as dictated by the treatment situation.

Introduction

The literature is virtually silent in regard to the process involved in entering and negotiating the role as a psychiatrist in a setting that is different from the therapist's own culture. The interplay of perceptions between therapist, staff, and client has a substantial impact upon developing relationships and treatment. Within this paper I would like to convey the complexities and nuances of this experience at the Indian Health Program through observations, case examples and persistent questioning of my role and function as a therapist.

The Indian Health Program (IHP) is located in a large urban area, and serves a population of 17,000 American Indians. Components within the facility include medical and dental clinics, Indian Child Welfare (ICW), an alcohol abuse prevention program, health education, administration, and fund raising. The IHP also houses and distributes food and clothing to needy individuals and families.

Negotiating a Role with the IHP

As a resident in psychiatry, I elected to utilize time during my senior year working at a facility providing care to American Indians. One of the most anxiety-producing aspects of accessing such a system was the length of time needed to negotiate my role. My supervisor, as an American Indian, was the primary facilitator during our initial discussions with the IHP staff. His cultural understanding and identity greatly assisted my entry into a

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system unknown to me. The mediating process with the health center began four months in advance of my actual placement there; the amount of time was imperative as the process was a slow one which involved numerous levels of exploration and discussion. Because the IHP did not have an organized mental health service, there was no well-circumscribed program area for me. Although this undefined role created much anxiety, it was beneficial in forcing me to learn approaches to a system, utilizing this open-endedness to focus my interests where my services were needed.

Meetings were arranged with the director and several other members of the IHP. An early difficulty was the recurring change of staff, requiring frequent renegotiation with new personnel. In retrospect, it was critical to have multiple key figures present at the meetings so that one need not start anew upon the departure of a major program. For example, during this negotiation phase the director of the program resigned; two of the three staff I eventually worked with were hired shortly before I began my placement. Early discussions focused on staff perspectives of the role they played in the local American Indian community, programs they had initiated, and current policies within the organization. Staff indicated that being Caucasian affected my understanding of their culture, yet they welcomed me in providing care for their people. During this time, it was important that I listen to their perspective, thereby enabling some initial trust to occur between us. Staff soon realized that I was not going to impose my expectations upon them. This approach allowed me to better understand the needs and difficulties of the organization rather than entering with a fixed agenda that could have alienated the staff.

During this time I wanted to set up a meeting with a woman who managed a program of interest to me. I left telephone messages for her to contact me, but received no response. I wondered if this lack of response was due to her personality or perhaps racial exclusion because I was non-Indian. Alternatively, I wondered if it was possible that her program was uncertain of receiving continued funding. I never discovered why my calls were not returned, yet through this experience I realized that one must continue to keep an open mind about disturbing behaviors. Rather than assuming reasons that may potentially compromise perspective and capacity to function in an unfamiliar setting, it is important to remember that there can be numerous explanations as to their cause.

As the negotiation continued, I began to focus more directly on my personal interest of providing psychotherapy for Indian women. ICW worked extensively with women, and could identify and provide referrals. During this phase of negotiation it was important not to promise more than I could fulfill. For example, the staff wondered if I would be able to participate in court hearings. After thinking about this possibility, I decided that this was a service that I would not be able to provide due to time constrictions. Staff wondered if there would be a fee for my services, and I clarified that my time would be without charge to clients. I also clarified the exact time period I would be available and that there could not be a

guarantee that another resident would replace me upon my termination at the clinic. Without this open discussion, expectations could have been raised that potentially could have caused many future problems.

Once a mutual understanding had been arrived at between the IHP and myself, our arrangement was formalized through a letter. In it, I described our agreed upon goals, my time commitment, and my appreciation for being given the opportunity to work with the IHP. I also personalized the letter by telling staff about my background, permitting insight into my non-professional life. This became my unofficial "contract" with the IHP.

Initiation of Clinic and Practice

The next stage of entry was to actually initiate my clinical role at the IHP on a regular basis. I requested an orientation to allow me to tour the various departments, thereby familiarizing myself with the services provided and introducing me to all employees. This also was a period during which the ICW staff became acquainted with me. In turn, I began to familiarize myself with the specifics of their program. We discussed several women the ICW staff had identified as potential clients, reviewing their case histories, needs, and willingness to participate in psychotherapy. Interview times were arranged by the ICW staff for these identified clients.

On my first day of clinic time, none of the scheduled clients kept their appointments. I became apprehensive that there would not be clients to work with despite my long hours of negotiating an area in which to work. In contrast, the following week I was very busy with several scheduled evaluations and an emergency client; contrary to my early apprehension, my services clearly were needed.

As I began seeing clients regularly and therefore became more known, I was aware of staff seeking me out to investigate who had come to work in their program. The program's medicine man repeatedly walked by my door; it seemed he wanted to observe me from a distance for a while. Another staff worker caught me in the hall and asked for an informal consult in assessing the needs of a non-Indian woman who had appeared psychotic. ICW staff began to communicate their concerns, to ask for direction, and to utilize me in a supervisory capacity. I, in turn, began to explore the varied aspects of my role at this program.

Evolution of Varied Roles

Upon entering the IHP, it was beneficial to have some perspective of these potential roles. As I became more familiar with the staff and programs, I became increasingly aware of the variety of functions I performed. My roles did not unfold gradually over time but seemed to occur almost spontaneously, changing quickly from moment to moment with a great deal of overlap. Initially this was quite confusing until I sorted out the

roles with the assistance of my supervisor. It was important for me not to limit myself to the role of therapist. As my roles at the IHP developed, so did the staff's ability to identify what I had to offer.

The variety of roles undertaken can be organized into several categories including therapist, consultant, facilitator and information contact. In retrospect, I entered the system perceiving myself primarily as a therapist--a role familiar to me as well as a self-imposed identity. My function as a therapist was to interview patients, assess their problems, and perform appropriate treatment. Yet as my contact time progressed, staff members approached me with different roles in mind. For example, staff began presenting case material to me with subsequent discussion which resulted in my performing in a consultation capacity. This was a role easily accommodated due to years of clinical training. I recognized the expertise I could convey and how to assist staff members with problem-solving.

Staff also searched me out as an information contact. For example, the director approached me regarding how mental health services might best be conducted at the facility over time. Another staff person requested information on referring a patient to an appropriate resource for mental health treatment. Alternatively, I began to develop my role of facilitator to help strengthen the skills and group cohesion of the staff. My initial, self-defined role as therapist greatly expanded.

Dynamic Aspects to the Roles

There are dynamic aspects to these roles that deserve special mention and can be referred to as flexibility, perspective-taking, and case management. More closely defined, flexibility involved a fluid accommodation of staff and program needs. Examples include acknowledging that this facility served a small and circumscribed community in an overlapping manner, with staff and clientele providing services to people they knew socially. I often found myself conducting therapy with a patient one moment and shortly thereafter socializing with the same person in a community meeting room in the facility. Although I had been trained to maintain a therapeutic distance from patients, this would not have been appropriate in this setting, as overlap between service and socialization is not only acceptable but is an important component of being accepted by the community itself.

Perspective-taking is an integral aspect of working as a psychotherapist in that one must be able to take into account the viewpoint of the other person in order to gain understanding and communicate effectively. For several reasons, it is particularly important in entering a specific cultural system. In working with staff and negotiating relationships, it is critical to consider the perspective that another might have adopted in approaching a given issue. An example was my observation that a staff member who initially was quite engaged with me suddenly became withdrawn and unavailable. I could have presumed that I had offended her

in something I said or did. In assessing this new behavior I considered another explanation: this staff member had divulged considerable of personal information in our discussions and as a result felt the need to distance herself. The appropriate response in this case was to give her the needed distance while maintaining an open door for communication, rather than asking if I had done something wrong. She was eventually able to return to a working relationship with me, which might not have been possible if I had been intrusive at an inappropriate time.

A second reason that perspective-taking is so important in this setting is that cultural differences and their implications for treatment must be ascertained. An example involved an Indian woman who was extremely upset with the school system, feeling that it had forced her to cut her son's long hair after allegedly finding lice. She felt the real issue was that school personnel had a difficult time accepting the length of her son's hair and utilized the lice issue to force compliance. It was important for me to know that long hair on an Indian boy is an integral aspect of participating in Native dancing. Without this knowledge, I would have been less able to understand the depth of trauma this woman had experienced. Not only had the school implied that she did not keep her son clean but she personally felt assaulted by the school's disregard of the significance of her boy's long hair to both his identity and hers as American Indians.

In working within a complex system such as the IHP, case management is an important element. There are multiple levels of problems to be assessed and coordinated to maximize treatment intervention. For example, a patient at the IHP more than likely has multidimensional needs. One patient who will be discussed in further detail needed an alcohol treatment program, individual psychotherapy to deal with her depression, foster care for her child while she was in treatment, and financial assistance to find housing and employment. All these were necessary to help her maintain sobriety. Each intervention integrally affected the others in that if only one or two needs had been addressed, treatment would have been likely to fail. In order to provide integrated care, it was important that I work closely with ICW staff. They knew the clients, their families, potential support networks, and the available community resources. The following case examples help to further elucidate the multiple roles and functions I assumed within this complex organization.

Case Examples

Case 1

B is a 25-year-old unmarried Northern Plains woman with a long history of alcohol abuse and mood swings (since 17 years of age). She had entered an inpatient alcohol treatment facility specifically for American Indian, and her 2-year-old son had been placed in foster care while she underwent treatment. B also has a 5-year-old son who lives with her sister

in a different state. She has not seen this older son for several years. Family history includes an alcoholic mother. As a result, B recalls constantly moving from place to place, never being sure where she would be at any given time. Other family members include two sisters from whom she feels alienated and a father she never met. B came to therapy motivated to make her life better.

In working with B, it was important to take into consideration the multidimensional aspects of her problems and needs. To receive optimal care she needed alcohol treatment, individual psychotherapy, foster care for her child, and financial assistance. In order to ensure an integrated approach, a case conference forum was established to exchange information and define treatment goals. Two care providers and I met together on a regular basis with additional phone contact to update information between meetings. For example, at one meeting the social worker shared foster care plans and the results of regular contact between B and her child. The alcohol counselor discussed B's work in the area of assertiveness as opposed to aggression. She also discussed the alcohol treatment program and gave an overall perspective of issues addressed over time. As the psychotherapist, I shared B's work on issues of loss and how that affected her current ability to maintain ties with people. Also discussed were long-term treatment goals and how to continue the support this woman needed after she completed her inpatient alcohol treatment program. We decided to help her widen her support network through additional resources.

At one point the client wished to attend one of these case conferences. On one hand she was curious about our discussions, and on the other hand she wanted to participate in her care. She was invited to a portion of one meeting and given the opportunity to state her concerns and goals. In return, the care providers discussed with her the current phase of treatment and future plans. It was helpful to all involved to have her actively taking an interest and participating.

With so many care providers, issues of confidentiality needed to be addressed. Permission was obtained from the client for allowing exchange of information among providers. She had the right to specify any personal information not to be shared. B agreed to this plan because she knew the case conference approach represented her best interests.

When multiple care providers work with a single individual, the question of competition between staff and potential interference with treatment may be raised. This was not an issue with B for several reasons. First of all, this client had so many needs that it was actually beneficial for the staff to share this burden as a way to provide support for one another and to prevent burnout. If one provider had been managing the case, it could have been overwhelming. Secondly, each provider shared her particular area of expertise, enabling the others to learn about this aspect of the treatment and thereby increasing the knowledge and understanding of the complexities of B's case.

Role flexibility was important in working with B. Early in her psychotherapeutic treatment, B would exhibit little affect; yet afterwards she would leave me and cry in the social worker's office. Typically, a psychotherapist works with affect within the session as an important part of the treatment. In this case, it was almost as if there were two co-therapists working separately. Initially, as B was gaining trust with me, she was more comfortable being tearful with the social worker whom she had known longer. At the end of each session, after B's departure, my colleague and I would discuss the case and work on treatment approaches together. This arrangement worked, but required a flexible approach. Eventually B was able deal with affect directly with me. A factor that quickened this process was my colleague's absence one day, forcing B to utilize our therapeutic relationship.

Role fluidity was also integral to working with my "co-therapist" in the case. At times I functioned as a supervisor to my colleague, helping her to maintain objectivity in working with B. At other times, she would function as my supervisor in helping to guide me through cultural aspects of the case with which I was unfamiliar.

In working with B, there were issues that required that she verbalize her anger. I was not sure if and how the expression of anger would be culturally appropriate and recognized that this was an area that needed a perspective of cultural sensitivity. I went to my co-therapist to inquire about this matter. She told me about the symbolism of the peace pipe, how it represents wisdom and goodwill; she told me that unless B's anger was dealt with she would not be able to attain that which the peace pipe stood for. With this knowledge I began working with B on anger from both past and current experiences. As B began to recognize her feelings, she talked about how she would repress her anger and end up drinking to deal with it. In therapy, she learned to talk about her problems and associated feelings, rather than using deeply ingrained self-destructive responses. Over the course of treatment, it became clearer that B's difficulties in dealing with her anger were due to personal issues rather than cultural ones.

It is very important to inquire about potential cultural aspects in dealing with clients, as this knowledge could be an integral part of treatment. Cultural sensitivity is an ongoing process of inquiry and self-instruction with an awareness that specific cultural factors may play an important role.

Case 2

N is a 13 year old girl from the southwest who was removed from her home by social services due to sexual abuse by her stepfather. N was eventually placed with her biological father (Mr. G) and his wife after not having seen him since her parents divorced when she was eight years old. Her mother reportedly had abused drugs for many years during N's childhood and had chosen to continue living with the stepfather despite the abuse allegations. N's father had been alcoholic when living with the family,

but had been sober for the past two years. He also worked at the program where N was treated.

Difficulties with alliance with N and her father were a problem from the onset of therapy. Although weekly appointments were scheduled, N attended sporadically, and Mr. G was resistant to his daughter receiving evaluation and treatment despite social services recommendations that she be in ongoing therapy. Consequently, flexibility and perspective-taking were important aspects of working with this family.

Due to sporadic attendance, it was important to have a set time so N knew she had an appointment every week regardless if she came. When N did not arrive for her appointment, I would leave my office door open and her father would stop by to talk during a break from his work. Initially he said N only needed to see me once or twice, that talking about the incest wasn't going to help her any. I took this opportunity to educate Mr. G about psychotherapy and how it could help his daughter, particularly with her inability to trust adults. At times he was so agitated he refused to discuss anything with me; at other times he shared the frustration he experienced in dealing with his daughter. Although he was never the identified patient, a major portion of treatment was accomplished through this "open door" policy. It would have been unlikely that N's father would have spoken with me via any scheduled appointment. He also had refused several offers of family counseling, which in my opinion would have been optimal in helping them to adjust to each other at home. Slowly over time, Mr. G's trust in me increased to the point that he brought N to the scheduled sessions on a more consistent basis. He seemed to respond to my willingness to disclose information without breaking N's confidentiality. Perspective-taking was important in recognizing the father's ambivalence about having his daughter in treatment. This understanding allowed me to educate and work with him in a comfortable manner. After approximately one month, N's father was able to share important information about his daughter and his relationship with her at home that was central to treatment.

N was distrustful in therapy and frequently angry. She experienced problems in adjusting to a new living situation and had developed maladaptive ways of dealing with people that had been present long before moving into her father's household. She began to share some things about herself, yet wondered if I was working for her father. She knew that he frequently spoke with me and was further confused by the fact that he worked at the IHP. I told her that information she wanted to remain confidential would not be discussed with her father unless it involved harming herself or someone else. Her only request was that I not discuss with her father what she told me about boys. Shortly thereafter she tested me by talking about her sexual activity and her desire for birth control. We talked about her concerns in regard to sexuality, noted that saying no was an option, and discussed where she could obtain birth control if needed. Although N continued to distrust me, she initiated some moves to establish a relationship with me. Although she was the identified patient, the therapy

consisted of treating both N and her father in tandem. My flexibility of being available to each, and in a way allowing them to regulate treatment is very different from the standard model of weekly therapy sessions with an individual. Recognizing that my time at the clinic was less than six months, reasonable treatment goals needed to be set for N and her father. It was decided that a viable plan would be to help her to establish a relationship with an adult in which N could begin to learn basic trust. A reasonable goal with her father was to help him understand his daughter, his reactions to her, and how to set limits. He also needed to be educated about the importance of consistent, ongoing therapy for his child.

Two months after beginning treatment, N was placed in a shelter by her social worker after she accused her father of sexually abusing her. The following day she rescinded this claim and agreed to return to live with him. Mr. G was angry and hurt by N's behavior and spoke at length about his feelings during one of our "open door" sessions. Yet, at the same time he began to take steps to understand N's behavior. He wondered if this might indicate that she hoped to return to live with her mother because she had never adjusted to leaving the home she had known for 13 years. It was helpful for him to vent his frustration and to have his feelings validated, as well as to problem-solve ways to deal with his daughter's behavior.

Following this incident, N consistently attended sessions until one month later when she missed a scheduled appointment. The following day she attempted suicide by overdosing on pills and was admitted to an adolescent treatment ward. Her father was angry with her, feeling that she had disregarded all he had done for her and was trying to get attention. He vacillated markedly between wanting to have nothing to do with her and recognizing that she had significant emotional problems.

It was important to help Mr. G recognize that his daughter's suicide attempt was a call for help. We spent several "open door" sessions talking about N, her needs, and his feelings about her refusals to see or speak with him at the hospital. He came to understand that she needed extensive treatment for her emotional problems--an important insight for him.

Several weeks into N's hospitalization, Mr. G refused to speak with me at the clinic. He would not come in to talk when my door was open, and he would walk away when I approached him. This dramatic change in behavior was puzzling. In taking perspective, I recognize that he may have needed this distance for unclear reasons. Perhaps he felt it was of no use to talk with me, since his daughter refused to talk with him. A colleague at the clinic reported that he had come to her several times to discuss his daughter. It seems that it was important for him to talk with someone not as involved as myself. In this manner, he could continue the process he had begun with me.

Once again the therapist should ask if cultural factors played an important role here. It seems more likely that N's case primarily had to do with a troubled adolescent who came from a chaotic childhood and

subsequently had an early developmental deficit in trust. Her response was to develop a way of dealing with it which was not culture-specific.

Case 3

S is a 37-year-old Northern Plains woman who was referred for difficulties in coping. Several months earlier her sister and brother-in-law died in a motor vehicle accident, leaving their nine children homeless. S agreed to take four of these children in addition to five of her own. The ages of the children ranged from 6 months old to 16 years. The eldest niece (D) manifested difficult behavior problems compounded by severe depression with chronic suicide threats. S was overwhelmed and began to exhibit signs of major depression, including decreased appetite with significant weight loss, difficulty sleeping, and feelings of helplessness and hopelessness. The niece's disruptive behavior had affected other family members to the extent that S's son also had become vegetatively depressed. S did not feel that she could cope with the situation and was constantly fearful that her niece would harm herself. She believed that she could manage to handle the other children if it were not for her niece.

The niece began treatment at a local mental health center and her social worker began to look into hospitalization. Phone calls were exchanged between the niece's therapist, the social worker, and myself; we agreed that immediate intervention was necessary to maintain stability within the home. This forum for the providers expedited necessary treatment: D was hospitalized that day.

Several follow-up appointments were arranged with S, but she cancelled each one. She reported by phone that she was feeling much better, that the depression had resolved, and that she was gaining back lost weight. Caring for the eight remaining children was taxing, but she was coping well. Her son was doing better and she thought that his depression was lifting.

In gaining perspective of this case it was important to identify my role as therapist. Initially, I believed that I would need to treat S for a major depression. As it turned out, I helped to facilitate the hospitalization of her niece, thereby alleviating a significant stressor. S did not need further sessions with me as her life and depression dramatically improved, and she could function again as the mother of all the children. Although she acknowledged her grief at the loss of her sister, she was managing these feelings on her own. The extent of intervention that S had needed had been completed.

Termination

My partings with clinic staff were varied. Many of the staff avoided saying goodbye either by not dealing with the issue or by arranging meetings on my last day and being unavailable. Other staff members were

able to acknowledge my leaving in a meaningful way by discussing the experience of my presence in the clinic and their feelings with respect to my leaving. As a token of closure, I left cards with personal notes attached for the people with whom I had worked most closely.

Terminations with patients were difficult. I had come to know B quite well and had seen the progress she had accomplished in therapy. During our last session she was quiet and withdrawn, unable to talk much about what she was experiencing other than feeling abandoned by me. Earlier I had decided to give B a small gift to remind her of our work together. I had heard that giving small gifts was a part of American Indian culture. As a therapist, giving gifts to a patient was something I had been taught to see as inappropriate; therefore this gesture on my part was contrary to my training. Yet I realized that my gift to B had an important bonding effect upon her. She brightened when I presented the small notebook for her to write poetry in and began to deal more directly with our parting. She, in turn, had a self-made gift that she gave to me, after she waited to see if I would give her a gift. I felt as if this exchange of gifts solidified our relationship, emphasizing that we cared enough to remember each other in a special way. Gift-giving in this population was an important cultural factor for me to consider as a therapist.

Alternatively, N said that she did not care that I would no longer be visiting her in the hospital. Yet, on our last day, she became angry and tearful with me. She also had learned that she would be leaving the hospital to enter a residential treatment facility which caused her a great deal of distress. I gave her a special card with a personal message about our relationship, towards which she acted indifferent. However, I noticed that she kept it close to her after running out of the room during our session. She was unable to acknowledge that our limited time together and my consistency had been important to her, but her behavior suggested that I had meant something to her.

Conclusion

I gained several important lessons through my experience in the IHP. A psychiatrist should not rigidly define his or her role upon entering a particular setting, but rather should allow the multitude of roles to unfold. After initial surprise at switching suddenly from one role to another, I soon became more fluid in this area as I acknowledged that it was the essence of my work there. Acceptance and an ability on my part to allow such changes offered the IHP a wider spectrum of my capacities and allowed me to experience the IHP on several levels.

I also learned that to be a culturally-sensitive psychotherapist, one must constantly consider the possibility of cultural influences upon treatment. This is a continual process of questioning, learning, and discovery that occurs when working within a culture different from one's own.

Cultural differences are important, as is a constant awareness of problems that might arise due to these differences. I had expected to find many cultural dimensions to my work at the clinic, yet I actually found that most of the therapeutic issues and conflicts were familiar. I discovered that basic human conflicts outweighed the differences. The universal suffering of human experience underscores that a culturally sensitive therapist can work with people from a different culture.

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