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SIP NEWSLETTER
Official Publication of the Society of Indian Psychologists

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NEWS ITEMS

CPPI / SIP LINK OFFICIAL

With the approval of the Executive Committee, SIP became a charter member of the Coalition for Psychology in the Public Interest. CPPI hopes to create a means whereby member organizations can cooperate to increase the application of psychology to a wide range of public interest issues. Among its goals, CPPI hopes to disseminate information to both policymakers and to psychologists, and encourage policy relevant research by psychologists and psychology students. As one member of the executive committee commented, "This may be a way to magnify our impact concerning the care and treatment of Indian people." A formal governing body for the Coalition was to be elected May 1990. Any member of SIP interested in serving as a liaison to CPPI is invited to contact any member of the SIP Executive Committee.

SIP TO CO-HOST 1990 APA EVENTS

Together with the Asian Psychological Association, SIP will co-sponsor the President's Breakfast for presidents of ethnic minority associations at the 1990 APA Convention in Boston. SIP will also share the cost of the Ethnic Minority Hospitality Suite.

The annual meeting of the Society of Indian Psychologists will convene on August 9, 1990 (6:00 - 9:00 pm) at the Wellesley Room, Boston Marriott Copley Plaza Hotel. This time was chosen to allow more time for discussion of issues and socializing. The agenda follows:

I. Administrative Business
   A. Executive Committee Membership
   B. Membership
   C. Treasurer's Report
   D. Newsletter

II. Organizational Linkages
   A. Ethnic Psychological Associations
   B. APA
   C. APS
   D. IHS
   E. BIA
   F. U.S. Congress
   G. Utah State University

III. Recruitment and Retention
   A. Students
   B. Faculty
   C. Professional Positions

IV. New Business
V. Announcements
VI. Social Hour

NL OPERATIONS CONSOLIDATE

As many are aware, SIP Newsletter operations have been spread across three states (NY, CO, OK) and two countries (USA & Canada). With this issue operations will be consolidated between the editorial office in NY and the National Center for Native American/Alaska Native Mental Health Research at the University of Colorado. Gratitude is sincerely extended to Bob Annis and his support staff in Canada whose efforts gave the NL its current attractive format. Appreciation is also extended to Wayne Rowe at the University of Oklahoma for his department's support of the NL; and to Sandra Bennett and Dee Bigfoot for timely reproduction and distribution. Without the support and dedication of these individuals, the NL would not have achieved its current level of quality.

The move to consolidate operations will hopefully streamline production so the NL can be distributed in a more timely manner. Plans currently are to publish a Summer and a Winter issue. In addition, the NL will now bear the entire burden of costs for assembly and publication. To this end, SIP can no longer afford to send the NL to non-members (i.e., those who have not paid their annual dues). If your membership dues are not paid up, this will be your last issue of the NL. As an additional means of obtaining funds for the NL, the business meeting held during the Boston APA Convention will adopt a policy and fee structure for advertisements appearing in the NL.

INDIAN ADOLESCENTS AT RISK AND UNDERSERVED

Indian adolescents suffer more serious mental health problems than the rest of the U.S. population. A report released in January 1990 by the Office of Technology Assessment (OTA) cited as causes physical and sexual abuse, alcoholism in parents, family disruption, and being "caught between two cultures" (p. 1). Exacerbating the situation are barriers to effective services such as lack of awareness or denial within communities; lack of preventive interventions in such areas as drug/alcohol

abuse; disorganized management within and between various agencies; and insufficient adolescent-trained mental health workers.

The report suggests a number of ways to remedy the current situation. Data collection systems must be must be coordinated among agencies (e.g., education, law enforcement, IHS, etc.), must address more sensitively child and adolescent diagnosis, and must be culturally sensitive to understandings of mental health and mental illness. Service availability and utilization, as well as an evaluation of treatment effectiveness, needs to be documented. Such data is currently unavailable. "Very little systematic research has been conducted on the effectiveness of specific therapies with Indian adolescents" (p. 56). Without data on mental health problems and therapeutic effectiveness which considers cultural variables. What is meant here, the report points out, is a "highly sophisticated form of intervention that should not be confused with the extensive array of cultural heritage classes and traditional value groups that perform important, but not necessarily therapeutic, functions in many Indian communities" (p. 52). Finally, the report points out that there are approximately .8 child/adolescent-trained mental health workers per 10,000 adolescents in IHS service areas. Adequate service would demand a ratio in the area of 4 or 5 trained professionals per 10,000.

The complete report, **Indian Adolescent Mental Health** (GPO #052-003-01175-1) is available for $3.50 from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402-9325.

ITEMS ON INDIAN ELDERLY NEEDED

The Winter 1990 issue of the SIP Newsletter will be devoted to the topic of Indian elderly. Spero Manson will be guest editor for this special issue. Anyone with articles or items which might be appropriate for inclusion should submit the material to Spero Manson, Ph.D., University of Colorado Health Sciences Center, C-249, 4200 E. Ninth Ave., Denver, CO 80262 by October 15, 1990.

MOVE TO REDUCE FEES FOR JOINT APA/SIP MEMBERSHIP

The Executive Committee of SIP has approved a proposal which would allow reductions in membership fees for new members joining both SIP and APA. The proposal would allow 20% reductions in first year memberships to those joining both APA and an ethnic minority psychological association. L. Phillip Guzman, Director of APA's Office of Ethnic Minority Affairs, in a letter to Candace Fleming, SIP President, states, "APA is interested in pursuing joint membership and has positively received the proposal of reduced joint membership....I believe our joint membership proposal will assist each association in increasing membership...."

NHPA SEEKS CONTINUING DIALOGUE WITH SIP

National Hispanic Psychological Association (NHPA) president, Victor De La Cancela, reaffirmed his organization's intention to maintain ongoing dialogue and cooperation with SIP and other ethnic minority psychological associations. In addition to providing updates on NHPA activities to various groups (e.g., involvement in APA's Task Force on Delivery of Services to Ethnic Minority Populations, encouraging development of university based student organizations, etc.), Dr. De La Cancela invites SIP members to participate in his organization's activities at APA in Boston.

URBAN INDIAN POPULATION LACKS MENTAL HEALTH SERVICES

Urban Indians have very real mental health needs that are not being met. In the mid 1970's, Community Mental Health Centers were designated to provide mental health services for de-institutionalized patients. It has been shown that Indian people generally do not go to community mental health centers. The reasons for this are varied, but one factor is that Native Americans view "mental health" much differently than non-Indians. A primary difference between Western and Native American orientations to mental health involves a difference of values. While the Western tradition of psychotherapy is client focused and attempts to provide therapy within a value-free framework, American Indian approaches to therapy rely on a holistic, community-involved perspective that implies a spiritual dimension as well.[1]

Psychological disturbance is often primarily a reaction to life conditions, and mental illness can be a tragic result of an unsatisfactory adjustment to a social-psychological environment that provides few satisfactory options for human action.

There are few studies currently underway that focus on the familial or sociocultural precursors of mental illness among American Indians. There are even fewer attempts to look at effective strategies currently employed by American Indians for coping with numerous stressors.[1]

Utilization studies of psychological services by Native Americans indicate a large disparity between American Indians in need and those who use such services. This disparity has been attributed not only to the difference in values and expectations among practitioners and clients, but also to neglect by government representatives and psychological professionals in promoting adequate mental health services or health maintenance activities.[2]

To investigate the need for Indian-specific mental health services in urban areas, American Indian Health Care Association contacted 35 urban Indian health programs. Information sought on mental health services included: funding sources, types of services provided, types of providers, most frequently reported reasons for visit, and available delivery methods (direct care, referral,

or no care). This information, combined with Fiscal Year 1987 Urban Common Reporting Requirements (UCRR) data on program users, program costs, and program encounters provides a good overview of mental health services currently available through the urban Indian health programs.

The survey shows that:

1. Expenditures for mental health services by urban Indian health programs represent about 3.8% of total expenditures for health services by the programs in Fiscal Year 1987;
2. The average annual expenditure per mental health service user has declined by almost 50% from Fiscal Year 1985 to 1987;
3. All urban Indian health programs provide at least one mental health service, the most common being referral to outside agencies;
4. The most frequently used type of mental health service provider is the M.S.W. social worker; and
5. The most frequently reported reason for visit is drug and alcohol abuse, followed by cultural adjustment issues.

Without exception, each of the thirty-five urban Indian health programs identified mental health needs among their client population which they cannot currently address for lack of staff and funding. Indian Health Service does not have funds specifically targeted for mental health services in urban areas. The urban programs find themselves in a situation where they either cannot provide much needed mental health services, or they must pursue other scarce funding resources in order to try to provide such services. As a result, mental health services offered by the urban Indian health programs vary widely in quantity and scope of services available. The pattern of mental health service provision and use indicates that comprehensive mental health service programs exist and are well used where there are funds to support.

For more information about mental health services delivery among the urban Indian health programs, contact American Indian Health Care Association, 245 East Sixth Street, Suite 499, St. Paul, MN 55101. Phone: 612/293-0233.

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[1]LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43*, 388-397.

[2]Liberman, D., & Knegge, R. (1979). Health care provider-consumer communications in the Miccosukee Indian community. *White Cloud Journal, 1*, 5-13.

[Reprinted from NEWSBRIEFS, March 1989, published by the American Indian Health Care Association.]

NATIVE AMERICAN TEENAGERS AT RISK FOR AIDS

World AIDS Day in 1989 was an attempt to get more people to think about AIDS on a personal, local and global level. The focus was on youth. As an AIDS educator, I made a special effort to reach audiences that hadn't had the opportunity to review their risks or think about what impact the disease had on their lives.

An in-service program was presented to the staff at American Indian Health Care Association. New videos were reviewed; and a short discussion followed. Issues such as homophobia and denial, both personal and community-wide, were discussed.

As the work day drew to a close, I thought that the job of teaching and informing would also close for the day. However, as we all know, the job of spreading the word about AIDS prevention will never be done, even if scientists do find a cure.

While visiting some young relatives in another city, the lack of precise information in the Native American population became evident. For although they were adequately informed about general facts about AIDS, they were less knowledgeable when it came to assessing their own risk, making decisions about HIV antibody testing, and planning a strategy to prevent HIV infection. It was even more a cause for concern for these young men since, as many young people, their high risk activities did not translate into self-perceived vulnerability.

Early mass media attempts to inform the public of AIDS has contributed to this feeling of invulnerability. Early reports indicated that high risk groups for AIDS were IV drug users, homosexual males and persons from Haiti (later deleted). Categorizing AIDS cases by population groups has lulled non-IV drug using heterosexuals into complacency. Assuredly, their risk is low, but it is not non-existent. Young heterosexuals who don't use IV drugs are even more sure of their invulnerability, due to the added misconception that AIDS effects only people over thirty.

The Centers for Disease Control and other researchers have reported that a significant number of teenagers engage in behavior that increases their risk of HIV infection.[1] The percentage of metropolitan girls who had ever had sexual intercourse increased by 15 percentage points between 1971 and 1979 to 45 percent.[2] The average proportion of never-married teenagers who have ever had intercourse increased with age. In 1982, the percentage of never-married girls who reported having had sexual intercourse was as follows: approximately 6% among 14-year olds[3], 18% among 15-year olds, 29% among 16-year olds, 40% among 17-year olds, 54% among 18 year olds, and 66% among 19 year olds.[4] Among never-married boys living in urban areas the percentages were even higher: 24% among 14-year olds, 35% among 15-year olds, 45% among 16-year olds, 56% among 17-year olds, 66% among 18-year olds, and 78% among 19-year olds.[5]

A high risk behavior for HIV infection is male homosexual intercourse. In a survey conducted in 1973, 5% of 13- to 15-year old boys and 17% of 16- to 19-year old boys reported having had at least one homosexual experience. Of those who reported having had such an experience, over half (56%) indicated that the first same-sex experience had occurred when they were 11 or 12 years old. Two percent of the respondents indicated that they currently engaged in homosexual activity.[6]

Another indicator of high-risk behavior is the number of cases of sexually transmitted disease among teenagers. Approximately 2.5 million teenagers contract a sexually transmitted disease each year.[7]

Twenty percent of all persons diagnosed as having AIDS have been 20-29 years of age.[8] Since the incubation period between HIV infection and symptoms that lead to an AIDS diagnosis can be as long as 5-10 years, some fraction of the 20-29 year age groups diagnosed as having AIDS were probably infected when they were still teenagers.

Other indications that teenagers are engaging in sexual activity are the pregnancy and birth rates for U.S. teenagers. The 1984 pregnancy rate for sexually active girls 15-19 years of age was 233/1000 girls.[9] The U.S. has one of the highest birth rates for teenaged mothers in the developed world.[10] There is evidence that Native American teenagers have an even high rate. Over 21% of American Indian births, compared to 4.7% of White births, in 1986 for Hennepin County (metropolitan Minneapolis) were to teenaged mothers. Nearly 18% of the American Indian births in 1986 for Ramsey County (St. Paul metropolitan area) were to teenaged mothers; the proportion for the White population was 6.3%. For chicago in 1986, the teenage pregnancy rate for American Indians was 16.4 percent; in Detroit, it was 17.3 percent.

Although high rates of sexually transmitted diseases and high rates of teenage pregnancy indicate that the teenage population is at risk for HIV infection, few teenagers believe they are at risk. One study of teenagers (ages 16-19) revealed that although 70% reported that they were sexually active, only 15% of this group reported that they had changed their behavior because of concern about AIDS.[11] In a recent survey of Native Americans, including teenagers, 66% of the respondents indicated that they thought their risk of getting the AIDS virus was low or none at all.

In the face of accumulating evidence of increased chance for HIV infection among Native American teenagers, behavior theorists are searching for effective ways to curb high risk behaviors. To date, most prevention efforts have been aimed at Gay White communities. The utilization of such prevention efforts for Native Americans teenagers not only ignores cultural teenagers not only ignores cultural differences but also the socio-political and economic differences. For example, Native Americans are over-represented in the ranks of the unemployed, the incarcerated, the undereducated, and the medically underserved. Native Americans have a long history of being devalued by the White majority. The smallpox epidemic, and the political motivations that surrounded some of the events, taught an early lesson: that Native American lives may be considered expendable. This message has not gone unheeded. Discrimination and racism have encouraged a distrustful relationship between Indians and Whites. A feeling of powerlessness, that is all too real, has contributed to a unique perspective on life for Native Americans. If an individual perceives that they are powerless to change far-reaching societal values, their actions become more short-termed rather than of the long-range, goal-setting type. The decision to use a condom to prevent a disease that may occur 5-10 years in the future may not make an impact on a teenager who may be facing more immediate concerns. As AIDS educators ponder the difficulties of translating increased knowledge levels into positive behavior changes, they must not ignore the socio-political and economic factors that may be more of a barrier to prevention than cultural factors.[12]

Discrimination and racism have raised their hurtful, ugly heads even more prominently as the AIDS epidemic has made its impact on people of color. Minorities in the United States have a disproportionately greater number of AIDS cases compared to their number of AIDS cases compared to their White counterparts. This dangerously adds fuel to a hot bed of racism. Attitudes such as "they have done it to themselves" and "they got AIDS because of their deviance" strengthen the "we/they" phenomenon so that blaming, ostracism, and rejection can occur. For a group of people, who are only too familiar with the impact of discrimination, the added stigmatization of AIDS may be overwhelming and unbearable. It may be more comfortable to deny that high risk behaviors are occurring rather than receiving another label such as "drunken Indian".

That a significant proportion of Native American teenagers are engaging in high risk behaviors should not be denied. Rather, we should continue to inform them of the facts about HIV transmission, effective means of prevention, and the socio-political ramifications of HIV antibody testing.

1CDC. Guidelines for Effective School Health Education to Prevent the Spread of AIDS. *MMWR, 37*(S-2), 10-13.

[2]Zelnick, M., & Kantner, J.F. (1980). Sexual activity, contraceptive use, and pregnancy among metropolitan-area teenagers: 1971-1979. *Family Planning Perspective, 12*, 230-237.

[3]Hofferth, S.L., Kahn, J., & Baldwin, W. (1987). Premarital sexual activity among United States teenage women over the past three decades. *Family Planning Perspective, 19*, 46-53.

[4]Pratt, W.F., Mosher, W.D., Bachrach, C.A., et al. (1984). Understanding US fertility: Findings from the National Survey of Family Growth, cycle III. *Population Bulletin, 39*, 1-42.

[5]*Tables and References.* (1981, June). Teenage pregnancy: The problem that hasn't gone away. New York, NY: The Alan Guttmacher Institute.

[6]Sorensen, R.C. (1973). *Adolescent sexuality in contemporary America.* New York, NY: World Publishing.

[7]Divison of Sexually Transmitted Diseases, Annual Report, FY 1986. Center for Prevention Services, DCD, US Public health Service, 1987.

[8]CDC. HIV/AIDS surveillance report. December, 1989.

[9]National Research Council. (1987). *Risking the future: Adolescent sexuality, pregnancy, and childbearing* (Vol. 1). Washington, DC: National Academy Press.

[10]Jones, E.F., Forrest, J.D., Goldman, N., et al. (1985). Teenage pregnancy in developed countries: Determinants and policy implications. *Family Planning Perspective, 17*, 53-63.

[11]Stunin, L., & Hingson, R. (1987). Acquired immunodeficiency syndrome and adolescents: Knowledge, beliefs, attitudes, and behaviors. *Pediatrics, 79*, 825-828.

[12]De La Cancela, V. (1989). Minority AIDS prevention: Moving beyond cultural perspectives towards sociopolitical empowerment. *AIDS Education and Prevention, 1*(2), 141-153.

[Reprinted from AIDSBRIEFS, December 1989, published by the American Indian Health Care Association.]

GENDER ISSUES IN ETHNIC, HETEROSEXUAL, AND LESBIAN AND GAY FAMILY PSYCHOLOGY

Bethany Hampton, PhD and Royce Scrivner, PhD have been appointed Co-Chairs of the Division of Family Psychology Gender Concerns Committee. The goals of this committee include: (1) develop an active membership for this committee, composed of psychologists with a primary interest in family psychology matters pertaining to gay and lesbian issues or heterosexual gender role issues; (2) interpret needs, desires and dynamics of gay and lesbian family members; and (3) work to lessen gender role stereotyping and to promote mutually satisfying couples relationships.

Royce, an openly gay psychologist, is interested in lesbian and gay family psychology. Bethany is interested in feminist family psychology. The Co-Chairs are aware that ethnic perspectives offer unique contributions to a study of gender and have appointed the following to the committee: Drs. Arthur (Andy) Horne, Ena Vasquez-Nuttal, Pamela (Pam) Thurman, and Chao-Ying Wang. Andy is chair of two doctoral dissertations on men's issues and is beginning a study of the male role in the United States, Venezuela, and Ireland. Ena has published on Hispanic gender issues. Pam, an American Indian, makes presentations on American Indian families and works with some transsexuals. Chao-Ying addressed issues of Asian American families. A Black psychologist is sought for the committee. For additional information contact Royce at 214/372-7036 (FAX: 749-7943) or write to him at: Psychology Service (116B) VA Medical Center, 4500 S. Lancaster Road, Dallas, TX 75216; or Bethany at 817/898-2303 or write her at: Department of Psychology and Philosophy, Texas Woman's University, P.O. Box 22996, Denton, TX 76204.

FROM THE FIELD

[This section of the NL is meant to supply readers with information on member activities. Information on should be sent to the NL editor for inclusion.]

Joan R. Saks Berman, a SIP member working at the Albuquerque (NM) Indian Hospital, had her article, "A View from the Bridge: Feminist Therapist Meets Changing Woman," published in Women & Therapy, Vol. 4(8), 1989. Joan has also been asked by the SIP Executive Committee to serve as network representative to APA's Committee on Women in Psychology. **Teresa LaFromboise**, past-president of SIP, chaired the OTA Indian Adolescent Mental Health Workshop which provided critiques of the OTA's report reviewed in this issue of the NL. **Candace Fleming** is coordinating the pre-doctoral internship in Psychology for American Indians and Alaska Natives at the University of Colorado Health Sciences Center. **Damian McShane** will be chairing the Third Annual Convention of American Indian Psychologists and Psychology Students at Utah State University the first part of August, 1990. **Diane Willis** is chairing the recently established Task Force on American Indian Mental Health of Division 29 (Psychotherapy) of APA. Several other SIP members are also working on the Task Force.

LETTERS

[The following letter was directed to Candace Fleming as president of SIP. A portion of that letter is reprinted here since it speaks to the positive impact both SIP and the Newsletter can have.]

Dear Dr. Fleming:

...My first SIP newsletter was wonderful! It felt good to read about the experiences of other Indians in psychology. Sometimes, it helps to know that others are encountering the same problems.

Several of my professors have requested copies of the newsletter, and are interested in subscribing, also. I have recently begun to speak to local and campus groups about my life as an Indian who was raised "White" and our history in this country. The information in "Discrimination Against American Indian Families In Child Abuse Cases" has caused a lot of discussion--do I dare say it raised some consciousness? Many people who work in the mental health field here said that it made them more aware of their agency's attitudes toward other ethnic groups, as well....

May the Grandparents be with you,
Pat McClanahan
University of Alabama

[The following is a letter sent by SIP President, Candace Fleming, to Senator Daniel K. Inuoye.]

Dear Senator Inuoye:

I recently heard about Senate Bill 1846 and I would like to commend you on your vigorous advocacy for Native Peoples in America. The Society of Indian Psychologists (SIP) is particularly interested in section 7 of the Bill which would provide post-doctoral training for psychologists who agree to serve in an Indian or Native Hawaiian health program....

The push to include psychologists on the IHS mental health team has only come within the last ten years or so. The American Psychological Association estimates that there are as few as 100 Ph.D. Indian/Native psychologists nationwide. (I am assuming that this does not include Native Hawaiians.) Most of these psychologists are trained in clinical or counseling but only a very few of those are currently serving in Indian and Native communities. The legislation proposed by yourself could provide a very attractive incentive for Indian and Native Ph.D.s to practice in underserved communities in exchange for post-doctoral training fellowships.

It is likely that most Ph.D.s who would pursue this program would be non-Indian/non-Native and the need for training about cross-cultural mental health issues becomes very apparent. A cross-cultural curriculum would not always be available within the post-doctoral programs. Thus, the Indian Health Service and Hawaiian health service system would have the responsibility of establishing adequate orientation which includes cross-cultural issues to the psychologists upon entry into service positions.

Retention of psychologists within the service delivery system is another extremely critical issue. The experience of being served by a health provider who remains in one's community for as brief a time as two years, had been identified time and time again as a feature of Indian Health Service which can greatly compromise effectiveness of programming. The development of credibility and "community/culture savvy" may take even more time for a mental health professional than it does for other health professionals. Thus, it behooves the health systems to proactively address retention issues.

The recruitment and retention of ethnic minority psychologists into positions that can enhance mental health programming in ethnic minority communities is a critical activity of the Society of Indian Psychologists....

Respectfully,
Candace M. Fleming
President, SIP

EDITOR'S COMMENTS

Spring and Summer. Times for planting and working towards harvest.

"Grime and sweat
running down
my forehead.
I feel it
running free
down my temples.
The muscles
in my arms
they suffer
from the weight
of my hoe
bearing down on
the roots of
the thistles
and bullheads."[1]

The Hopi poet, Ramson Lomatewama, describes the work. The work of nurturing an organization like SIP is different, but also difficult. It has its sweat and pain. But seeing growth is a reward. There is heightened interest in SIP, and an increase in membership applications. Reviews of an article and a book in this issue of the NL point to areas in which SIP members are working. And yet there are many ways in which things are out of balance, not in harmony. Much work still lies ahead.

"In the beginning, we are told, Taiowa, the Creator, gave us his life plan, as it is written on the rock of Oraibi, which we call the prophecy. If we hold fast to the sacred way as he devised it for us, what we have gained, we will never lose. But still, we have to choose ... We are all the caretakers of life. The balance of nature depends on us. The world will be what we want it to be."[2]

Only once a year do the members of SIP really have an opportunity to get together, share stories, and celebrate progress. As we assemble from all our little parts of the world, we generate a shared sense of power and hope. It is easy for a small organization to become lost in the flurry of activity and masses of people that make up APA and its annual convention. The sense of identity is diluted and dispersed. Coming together provides the medium through which we again realize that we are in a real sense caretakers. That we share a responsibility.

You are invited to share with us in the work of planting and nurturing the goals of SIP, to insure that the mental health needs of Indian People are heard and addressed. If you will be in Boston, please join with us when we gather Thursday evening, August 9. And if you cannot join us, forward your thoughts, suggestions, ideas to a member of the executive committee so that your power can be added to the gathering.

[1]From "The Song of the Hoer" (1983). In Ramson Lomatewama, *Silent winds: Poetry of one Hopi*. Hotevilla, AZ.
[2]From Robert Boissiere (1986). *Meditations with the Hopi*. Santa Fe, NM: Bear & Company, p. 110 & 113.

SCHOLARSHIPS/GRANTS/TRAINING

PSYCHOTHERAPEUTIC INTERVENTIONS WITH ETHNIC MINORITY CHILDREN AND FAMILIES, June 14-15, 1990, University of New Mexico Conference Center, Albuquerque, NM. This conference has a significant number of workshops addressing American Indian issues. Although too late to participate this year, write to receive information on other offerings: Office of Native American Psychiatry, Department of Psychiatry, 2400 Tucker, N.E., Albuquerque, NM 87131 [505/277-5416].

THIRD ANNUAL NATIONAL CONVENTION OF AMERICAN INDIAN PSYCHOLOGISTS AND PSYCHOLOGY STUDENTS, co-sponsored by the American Indian Support Project (AISP) at Utah State University and Indian Health Service Mental Health. Tentative date is August 2-7. Convention chair is Damian McShane. For further information contact the Department of Psychology, Utah State University, Logan, UT 84322-2810, phone 801/750-1466.

HELPING THE NATIVE HELPERS, a three day seminar sponsored by the Native Mental Health Association of Canada. September 15, 16 & 17, 1990 at the Westbury Hotel, 475 Young Street, Toronto, Ontario M4Y

1X7, telephone 416/924-0611. Advance registration is $225 ($250 after September 1). Topics will include burnout and stress management, Balint groups for Native helpers, consultation networking, and other topics. For further information and registration contact the Association at Box 89, Shannonville, Ontario K0K 3A0, telephone 613/966-7619.

CHEMICAL DEPENDENCY COUNSELOR TRAINING full scholarships available from Hazelden and Grotto Foundations for American Indians. Interested applicants should contact Jane Peterson, Secretary, Counselor Training Program, Hazelden Foundation, Box 11, Center City, MN 55012. Phone 612/257-4010 ext 4545.

PROFESSIONAL PSYCHOLOGY PRE-DOCTORAL INTERNSHIP (APA-Accredited Program), rapidly-expanding community mental health center with exceptional range of treatment options for adults and children. Very stable organization located in the beautiful Ozarks lake region of southwest Missouri. Low cost of living. Community of less than 200,000. Seeking minority applicants. Complete information package available, upon request, from Patricia A. Stewart, Ph.D., Burrell, Inc., 1300 Bradford Parkway, Springfield, MO 65804, (417) 885-5275.

BOOKS/ARTICLES/VIDEOS NOTED

In "A View From Rainbow Bridge: Feminist Therapist Meets Changing Woman," Joan Saks Berman, Ph.D., uses her personal experiences as a non-Indian therapist to help others increase their cultural sensitivity when engaging in psychotherapy with Native American women. She uses the Ethnic Validity Model (Tyler, Sussewell, & Williams-McCoy, 1985) as a conceptual framework. This model presents three kinds of ethnic validity: (1) convergent: which pertains to patterns of interaction which are transcultural, (2) divergent: patterns of interaction which are unique to a specific culture, and (3) conflicting: patterns of interaction which are different from and in conflict with the dominant culture. This model stresses racial and ethnic variables rather than personal/individual factors when working with a client. The case summaries provided by Dr. Berman focus on examples of divergent and conflicting validity as she states, "these are areas where non-Indian therapists working with Native Americans might need more cultural sensitivity."

Dr. Berman describes several areas that may be problematic for therapists new to treating Native Americans. These areas include conflicting views of appointments times, the issue of continuity of treatment, witchcraft, the client's commitment to their clan versus the outsider, and male dominance. Therapists of all cultures need to be sensitive to the beliefs and biases of their client and frame their interactions within the context of their client's distinct cultural values. This article thoughtfully demonstrates the application of this concept. It is helpful as an introduction for those practitioners unfamiliar with Indian people and presents a useful conceptual framework for experienced therapists. [Reviewed by Teri Gallenstrin, Ph.D., a SIP member and psychologist currently working on the San Carlos Apache Reservation in Arizona.]

VIDEO ON ELDER ABUSE has been prepared by the Inter Tribal Council of Arizona. The video deals with physical abuse, emotional neglect, financial exploitation, and caretaker pressure. Copies are available for $25.00 from Regine Goerke or Violet Mitchell, Inter Tribal Council, 4205 North 7th Avenue, Suite 200, Phoenix, AZ 85013. Phone 602/248-0071.

CIRCLES OF WOMEN: PROFESSIONAL SKILLS TRAINING WITH AMERICAN INDIAN WOMEN, by Teresa D. LaFromboise, available from WEEA Publishing Center, Education Development Center, Inc., 55 Chapel Street, Newton, MA 02169.

The title, Circles of Women, is taken from a vision of balancing women's contemporary and traditional roles. The work is intended as a manual for "leadership training workshops with American Indian women" (p. vii). The ability to navigate between and function successfully in two cultures is a skill, at least to my knowledge, which is learned by personal trial and error and not taught in any structured way. This manual is an exception. It begins with an enumeration of the stresses and strains which biculturalism cause for the individual Indian woman--difficulties which often inhibit success in the Anglo culture and also provoke suspicion on the part of her own Indian culture. From here the book proceeds to spell out a training model for bicultural competence.

The program is divided into four training modules or workshops. The workshops are organized so that they can be presented within either a one day or three day format. Since there is an enormous amount of material and training involved, it seems that the three day format might prove most effective. Implementation of this program also demands preparation and coordination on the part of workshop organizers. Various materials and forms must be prepared for participants. (The manual includes numerous forms which apparently can be reproduced directly since they do not appear to be copyrighted.) Also, some material must be obtained directly from the author (for example, an audio tape used in one of the modules).

Workshop 1 is organized around the theme of self-awareness and self-esteem. Exercises focus on personal and professional awareness always within a bicultural context. An important component incorporated into the final phases of the workshop is the opportunity for participants to interact with professional Indian role models around personal/professional, cultural and psychological issues. Workshop 2 deals with assertiveness. A cognitive-behavioral approach (instruction, modeling, rehearsal, cognitive restructuring, etc.) is augmented by incorporating a behavioral analysis of differences between Indian and White communication behavior. Workshops 3 and 4 become much more pragmatic and practical dealing with Career Planning and Financial Management. Dr. LaFromboise's expertise is

particularly apparent in these sections which make career education particularly context sensitive. The competitiveness inherent in presenting a noticed resume or the implied importance of material possessions in financial management are values not emphasized in traditional Indian cultures. The author does an excellent job of walking participants through the nuts-and-bolts are getting a job and surviving financially.

CIRCLES OF WOMEN is an excellent resource and essential for anyone involved in training Indian women professionals. Although some training exercises are allotted time that seems insufficient to achieve the stated goal (Relaxation is given only one 20 minute time slot for a progressive muscle relaxation exercise with no attempt to generalize the relaxation response through such techniques as autogenic training or imaging.), overall the manual provides an excellent framework for teaching essential skills within a biculturally sensitive context. It also would be fairly easy to adapt the material to a college level seminar and perhaps even a high school curriculum on career education. [Reviewed by Glenn Humphrey, Ph.D., SIP Newsletter Editor.]

AFFIRMATIVE ACTION IN PERSPECTIVE, by Fletcher A. Blanchard and Faye J. Crosby, available from Springer-Verlag, 175 Fifth Avenue, New York, NY 10010 for $39.00 or the Society for the Psychological Study of Social Issues, Box 1248, Ann Arbor, MI 48106 for $19.50.

How can society undo the legacy of racial and sexual discrimination in its institutions without engaging in reverse discrimination? Do centuries of injustice--in which some groups have oppressed others--require that those who were unfairly advantaged shall now be unfairly disadvantaged? How, in a world of static or diminishing resources, shall some be compensated without unacceptable costs to others?

These questions, difficult in the abstract, become especially problematic when we come to practicalities. For a while, a policy of equal opportunity appeared to be the answer to the racial and gender injustices of American society. But the policy of equal opportunity operates fairly only in a system that does not distinguish between groups either de jure or de facto, either intentionally or unintentionally, either blatantly or subtly. If racism and sexism exist in America, then equal opportunity is not a feasible policy for American institutions.

AIDS EDUCATION MATERIALS available from the American Indian Health Care Association (AIHCA). The Guiding Hand presents information to Native American teenagers on the causes and prevention of AIDS in a comic book format. When a Native Person is Told that He or She has AIDS, Many Different Feelings Come Out deals with issues surrounding diagnosis with a terminal illness and is helpful for friends and family of those with AIDS. Why Should I Be Concerned About AIDS Just Because I Have a Drink Once in a While discusses the link between alcohol use and unsafe sex. Are You Wondering How to Get Your Partner to Use a Condom? offers practical suggestions regarding condom use. How to Talk With Your Kids About AIDS and STDs offers suggestions to parents about bringing up the subject of sexually transmitted diseases, and reminds parents that kids are already receiving many sexual messages daily from the media. Free sample of (1-50) materials is available to Native Americans from Joan Myrick, AIDS Education Coordinator, American Indian Health Care Association, 245 East 6th Street, Suite 499, St. Paul, MN 55101. Phone 612/293-0233.

LIVING SAFE: Knowing about AIDS is a 16 minute video developed by the Devils Lake Sioux Tribe filmed on the reservation and depicting the impact of AIDS on Native American life. Available for $27.50 from Ila Lohnes, Tribal Health Programs, Devils Lake Sioux Tribe, Fort Totten, ND 58335. Phone 701/766-4236.