SIP NEWSLETTER

Official Publication of the Society of Indian Psychologists

Vol. 3, No. 2

Summer, 1992

NEWS ITEMS

1992 ANNUAL MEETING
OF THE SOCIETY OF INDIAN
PSYCHOLOGISTS

August 13, 1992
~~Nathan Hale Room~~
Sheraton Washington Hotel
2660 Woodley Rd at Conn Ave, NW
Washington, D.C.
Telephone: 202/328-2000

AGENDA

I. Business Meeting: 9:00 am - 12 Noon

   A. Administrative Business
      1. Election of President-Elect
      2. Membership Committee Report
      3. Treasurer's Report
      4. CEMAPA Report
      5. Student Liaison Reports
      6. Place/Date of 1993 Meeting

   B. By-Laws Committee
      1. By-Laws, SIP
      2. Articles of Incorporation, Colorado
      3. Tax Exempt Status, Federal

   C. New Business

II. Invited Presentations: 1:30 pm - 5:00 pm

We have invited SIP members from various regions of the country to do a 15-minute presentation addressing a topic of interest relative to American Indian psychology (Teaching, Research, Practice). They will also share regional news for 10 minutes which will be followed by a 5-minute discussion period. No tribes will be identified by name unless permission has been given to do so.

   A. Regions:
      1. Western
      2. Northeastern
      3. South Central
      4. Great Lakes
      5. Alaska
      6. Canada

   B. Issues:
      1. Training
      2. National Perspective on policy
      3. National Perspective on Practice

III. Reception: 5:00 - 7:00 pm

Beverages and hors d'oeuvres will be available and will be partially subsidized by SIP. Attendees will be asked to contribute $ 6-8.

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1992 SIP MEMBERSHIP DRIVE

The SIP 1992 Membership form that was inserted in the Winter, 1992 issue of the SIP Newsletter was planned to be the only notice of membership renewal. If you have not had a chance to renew, please do so at your earliest opportunity. Projects requiring funds cannot be adequately developed until most members renew.

The Society of Indian Psychologists is becoming known to more people and organizations from many sectors of the country. Many have heard because someone xeroxed a copy of the SIP Newsletter and passed it along. Anyone interested in mental health issues in Indian and Native communities is welcome to join. A dues waiver may be provided by sending a written request with the membership form found in each Newsletter issue. The 1992 membership statistics are summarized below:

Renewing Members:	57
New Members	07
TOTAL:	64

1992 SIP MEMBERSHIP DRIVE (CONTINUED)

Two members paid 1993 dues and one member paid 1994 dues. Six members contributed a total of $80 above and beyond the dues level. Thank you for your generosity!

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BY-LAWS ARE READY FOR YOUR REVIEW

The draft by-laws are included in this Newletter mailing for review by the SIP members. Please bring your copy to the business meeting on August 13, 1992. If you cannot attend the meeting, you are invited to mail in your comments on the form provided.

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ETHNIC MINORITY AGENDA 1991-1993

Office of Ethnic Minority Affairs
American Psychological Association

I. NETWORK BUILDING:

A. APA CEMA
- Linkage with Science & Education Directorates

B. STATE CEMAs
- Establish more State CEMAs
- Agenda for State CEMAs to be developed

C. DIVISIONAL CEMAs
- Assist in 1992 EM Mini-Convention in D.C.
- Develop a mutual agenda for Div. CEMAs

D. CEMAPA
- Joint membership project
- Increasing EM questions on State Lic. Exam
- Education and training issues
- Legislative issues and network advocacy

II. INCREASE VISIBILITY:

A. APA GOVERNANCE
- Survey ethnicity of governance members annually
- APA CEMA to develop a systematic nomination procedure

B. PUBLICATIONS
- APA CEMA to seek more articles in Monitor
- APA CEMA to seek publication of articles on Violence and Minority Male-Only Schools
- Increase EM editors by developing a mentorship project with the Council of Editors

C. DATABASES OF EM PSYCHOLOGISTS
- OEMA to develop database on EM psychologists, graduate students and undergraduates

D. APA CONVENTION ACTIVITIES
- Distribute listing of EM convention activities
- Develop 1992 EM Mini-Convention

E. RECRUITMENT & RETENTION
- Develop/revise Financial Aid Booklet
- Survey grad. dept. on recruitment & retention strategies
- Develop/revise Job Bank to recruit faculty
- Develop mentoring programs
- Impact National Undergraduate Conference
- Convene Task Force on Recruitment & Retention and implement recommendations which include:

  1. Undergraduate Student of Excellence Project
  2. National conference on EM recruitment, retention & training
  3. Seek funds to accomplish this project

- Training
- Impact accreditation process by increasing importance of Criteria II
- Disseminate APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations
- Publish Casebook companion to the Guidelines
- Assist in publication of APA book on EM recruitment and retention (Myers, Wohlford, Guzman & Echmendia)
- APA CEMA to collect multicultural training syllabi as recommended by Task Force on Recruitment & Retention

F. SCIENCE AND RESEARCH

- CEMA Dissertation Award
- CEMA to develop liaison with BSA to:

F. SCIENCE AND RESEARCH (CONTINUED)

1. Pay for student travel of dissertation awardee
2. Make dissertation award at BSA Science Weekend during APA Convention
3. Impact CPTA nominations
4. Value and increase EM research
5. Participate in NSF proposal to increase EM researchers

III. ADDRESS TREATMENT/SOCIAL ISSUES:

A. ETHNIC MINORITY VIOLENCE

- APA CEMA to develop related papers for publication

B. MINORITY MALE-ONLY SCHOOLS

- APA CEMA to develop related papers for publication

C. AMERICAN INDIAN MENTAL HEALTH

- Via IHS support, make annual site visits to reservations

D. GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES TO ETHNIC, LINQUISTIC AND CULTURALLY DIVERSE POPULATIONS

- Disseminate and promulgate the Guidelines
- Publish a companion Casebook to the Guidelines
- Work with state psychological associations to incorporate the Guidelines

If you need additional information, contact: American Psychological Association, Office of Ethnic Minority Affairs, 750 First Street NE, Washington, D.C. 20002-4242, Phone (202) 336-6000.

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FEATURED ARTICLE

THE SUCCESSFUL RURAL MENTAL HEALTH PRACTITIONER: CHALLENGES AND OPPORTUNITIES

The successful rural mental practitioner is also one who effectively responds to the realities of rural practice. The realities of rural mental health practice embody both challenges and opportunities. Success is often determined by how the practitioner needs to understand these realities in their full implications without the distortions so often found in romantic or cynical thinking. Second, the practitioner needs to have a positive acceptance of these realities. Third, the practitioner must be able to see clearly both the strengths and weaknesses of each of these realities and their contributions to any given practice situation. This is necessary if the practitioner is to effectively make use of the opportunities and to meet the challenges posed.

The realities of rural mental health practice can be grouped into environmental realities and practice realities. Environmental realities are those characteristics of rural areas that affect the delivery of mental health service. Practice realities are the specific factors that appear to characterize rural mental health practice.

••Environmental Realities

There are at least four major environmental realities that characterize rural areas and directly affect rural health care delivery.

Distance. While distance, as a factor, may vary among rural areas (obviously more of a factor in frontier areas), it is still a universal characteristic of rural that greatly influences service delivery. The distance between where people live and the service they may need is one factor, and the distance between a given mental health care service and other mental health care services is also a factor.

Weather. Weather greatly compounds distance issues and creates formidable obstacles to the access to services during certain times of the year in many rural areas.

Cultural Differences and Diversity. There is no single type of rural area. In fact, rural areas are characterized by a heterogeneity of population. There is greater diversity within the categorization of rural than between the rural-urban distinctions. This heterogeneity is reflected in great cultural diversity that requires a broad knowledge on the part of rural mental health practitioners and the extreme flexibility in rural mental health care delivery systems. And, in certain rural areas, there may be folk beliefs and/or folk healers that must be taken into account, and sometimes incorporated in service delivery.

Lack of Resources. Rural areas tend to be resource poor in the full range of health and human services. This often requires rural mental health practitioners to be many more things to their clients than their urban counterparts, and it means that the variety of support services that are often desirable as an adjunct to treatment or rehabilitation may be unavailable.

••Practice Realities

There are certain generalities that characterize rural practice that are both challenge and opportunity for the rural practitioner. While some of these issues are unique to rural practice, many of the following practice realities may be faced by both rural and urban practitioners but are either more critical or have greater consequences in rural areas.

Relationship to the Community. Unlike their urban counterparts, rural mental health practitioners have a relationship not only with their patients, but also with the community. Most rural communities have a set of expectations about "their" mental health professionals, and they demand a particular relationship of that professional to the community. While the specifics of that relationship may vary greatly among rural communities, the existence of that relationship is one of the key things that distinguishes rural and urban mental health practice.

Generalist Role. Perhaps the most consistent discussion in any literature of rural mental health practitioners is the fact that they must be generalists. The nature of rural practice requires that the rural practitioner be prepared to see a wide variety of disorders and age groups. Typically, the population density of rural areas precludes any great degree of specialization due to the low volume of any particular type of disorder or special population.

Role Diffusion or Role Blurring. Role diffusion and role blurring refer to the fact that in rural mental health practice the boundaries of one's professional role may be considerably more fluid than one's urban counterparts, both in terms of relationship to the duties of other occupations and professions and in regard to other social roles. The rural mental health practitioners (e.g., social worker, occupational therapist) or other occupations (e.g., clinic administrator, receptionist, van driver, public relations person, fund raiser, etc.). Further, rural mental health practitioners may be called upon in the capacity of their social roles to exercise professional judgment or practice. for example, a rural mental health practitioner, as a member of a school board, might be asked to render a professional judgment about a school employee that has become a problem for the administration. Finally, rural mental health practitioners may find that the citizens of the community make little distinction between evaluations of their professional and personal conduct and competence. In other words, the community perception regarding rural mental health practitioners' performances as parents may carry equal weight to their performances in mental health care delivery in determining the community's perceptions of their professional competence.

Isolation. One of the most often complained about realities of rural mental practice is professional isolation. Rural mental health practitioners may ave few, if any, colleagues upon whom they can draw for professional support, consultation and backup. There are also likely to be few opportunities for professional development and continuing education, as well as access to specialized resources, such as medical libraries and other resource support services. In addition to professional isolation, the newly arrived rural mental health practitioner may also experience personal isolation. Rural communities can be closed social worlds that take a long time to penetrate and, in many cases, the stability of the community is such that one needs to be second or third generation before there is inclusion into inner circles.

Ethical Dilemmas. More than their urban counterparts, rural mental health practitioners face a variety of ethical dilemmas, are at greater risk for discovery of breaches of ethics, and are more likely to have the entire community aware of any ethical failings. On the other hand, given the shortage of health care professionals in rural areas, communities may tolerate ethical failures for a longer period of time than their urban counterparts. Because rural communities are small, rural mental health practitioners are likely to be involved with their patients in a variety of other social roles (friend, banker, board member, service provider, policeman, etc.). The rural health practitioner brings to these encounters "special knowledge about these individuals" that poses a variety of ethical dilemmas. For example, suppose you're a rural health practitioner and your child has been invited to spend the night with one of his school friends whom, by virtue of your position, you suspect is a victim of incest.

Lack of Anonymity (High Visibility). The "fish bowl" environment of small-town life can be a strain for rural health professionals who have more urban backgrounds. For many rural mental health practitioners, this high degree of visibility is a double-edged sword in relationship to their practice and clientele. On the one hand, the high degree of visibility and lack of anonymity can marshal extensive support to an individual or family struck by mental illness. On the other hand, this high degree of visibility can also greatly compound the effects of stigma for individuals or families trying to cope with mental health problems. On the positive side, this high degree of visibility often means that rural health practitioners get to see firsthand the results of their clinical interventions in everyday life. However, it can also be a constant reminder of failures.

Burnout Vulnerability. One of the biggest challenges rural mental health practitioners face is not getting overwhelmed by their practice. The shortage of rural mental health practitioners and the wide variety and intensity of mental health needs present in the rural environment can easily overwhelm the rural mental health practitioner. If not careful, rural mental health practitioners will find themselves working nights and weekends, foregoing vacations, and neglecting friends and family. Such a pattern soon takes a heavy toll on practitioners, reducing their effectiveness and leading to professional burnout.

Reciprocity. Far more than their urban counterparts, rural mental health clients demand a reciprocal relationship with rural mental health professionals. Persons in rural areas are uncomfortable with totally one-sided relationships and want the opportunity for some form of reciprocity in the patient/practitioner relationship. Wise rural mental health practitioners actively search for opportunities for their clients to have opportunities to reciprocate as part of their relationship with them. (Reprinted from The Montana Psychologist, April 1992)

FROM THE FIELD...

NATIONAL INDIAN HEALTH BOARD

The National Indian Health Board (NIHB) has reopened their Corporate Offices. The location of the new NIHB office is 1385 South Colorado Boulevard, Suite A-708, Denver, Colorado.

The reopening of the NIHB office was made possible by a Cooperative Agreement between the Indian Health Service (IHS) and the NIHB. The IHS/NIHB agreement was signed on August 15, 1991, at the Tribal/IHS National Consultation Conference held at Spokane, Washington. The IHS/NIHB Agreement includes goals and objectives that are designed to assist all Tribes to protect their right to adequate and proper health care and services.

The goals of the NIHB are to:

1. Provide advice to and consult with indian health care consumers on problems and issues identified by the NIHB on which IHS needs to take action;

2. Facilitate Indian health care consumer networking and actively report on topics related to IHS policy, proposed or existing IHS program activities, and the impact of proposed legislation on Indian health care;

3. Publish a quarterly newsletter; and ordered 7-1-92

4. Coordinate and present an annual national Indian health care consumer conference.

NATIONAL INDIAN HEALTH BOARD (CONTINUED)

The NIHB will have a staff of four during the first year and add another during the second year. The staff will include the Executive Director, a secretary, an Administrative Assistant, a Finance Office/Budget Analyst, and a Policy Analyst.

The present officers of the NIHB are Andrew Lorentine, Chairperson (Tucson), Julia Davis, Vice-Chairperson (Portland), Buford Rolin, Secretary (Nashville), and Deanna Bauman, Treasurer (Bemidji).

For additional information and/or questions, contact the National Indian Health Board, 1385 S. Colorado Blvd., Suite A-708, Denver, CO 80222 or call (303) 759-3075. The fax number is (303) 759-3674. (Reprinted from Tribal Activities Bulletin, Volume 1, Issue 3, Spring 1992)

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WHITE HOUSE CONFERENCE ON INDIAN EDUCATION

The White House Conference on Indian Education (WHCIE) was held January 22-24, 1992, at the Ramada Renaissance Techworld in Washington, D.C., as provided for in the Hawkins-Stafford Elementary and Secondary Improvement Amendments of 1988 (P.O. 100-297, Part E).

The purpose of the meeting was to: 1) explore the feasibility of establishing an independent Board of Indian Education that would assume responsibility for all existing federal programs relating to the education of Indians, and 2) develop recommendations for the improvement of educational programs to make the programs more relevant to the needs of Indians.

Topics discussed at the conference were the result of over a year of work throughout the country. Eleven conference topics were identified:

* Governance of Indian Education and Independent Board of Education;
* Well Being of Indian Communities and Delivery of Services;
* Literacy, Academic Achievement, and High School Graduation;
* Safe, Alcohol/Drug-Free Schools;
* Exceptional Education;
* Readiness for School;
* Native Languages and Culture;
* Structure for Schools;
* Higher Education;
* Native and Non-Native School Personnel; and
* Adult Education and Lifelong Learning/Parental, Community and Tribal Partnership.

A final report on the WHCIE will be submitted to the President of the United States by May 22, 1992. The President will respond to the findings within 90 days after receiving the report. Rather than focusing on already well-documented existing problems, the final report will forecast courses of action based on those recommendations which were developed by conference delegates. The final report will serve as a blueprint for goals to improve education that are relevant to the needs of American Indians.

For more information on the WHCIE, contact Dr. Benjamin Atencio, White House Conference on Indian Education, 1848 C Street, NW, MS 7026 MIB, Washington, D.C. 20240 or call (202) 208-7167. (Reprinted from Tribal Activities Bulletin, Volume 1, Issue 3, Spring 1992)

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THE STATE OF NATIVE AMERICAN HEALTH: A UNIVERSITY OF MINNESOTA STUDY

A survey conducted by the University of Minnesota and funded in part by the Indian Health Service (IHS) is the most complete compilation of data ever gathered on the lifestyle and health habits of rural Native American youth in grades seven through twelve. Information was based on surveys from nearly 14,000 students from 50 different tribes in nearly 350 schools located in 15 states. It was undertaken to fill a wide gap in knowledge about the

MINNESOTA STUDY (CONTINUED):

health of Native youth. An article on the aggregate findings was published in the March 25, 1992, issue of the Journal of the American Medical Association. "This survey has revealed a complex web of health problems and risk behaviors that are interconnected," said Robert Blum, M.D., Ph.D., principal investigator for the study. "We now have a blueprint for action that we did not have before against the alarming physical and emotional health problems endured by these youth."

Members of Congress active on Native American health issues joined the principal investigators and Everett R. Rhoades, M.D., Director, IHS, at a Washington, D.C. news conference to announce the findings reported in a publication entitled "The State of Native American Youth Health." They included Senator Daniel K. Inouye (D-HI), Chairman of the Senate Select Committee on Indian Affairs; Representative George Miller (D-CA), Chairman of the House Committee on Interior and Insular Affairs; and Representative Patricia Schroeder (D-CO), Chairwoman of the House Select Committee on Children, Youth, and Families.

The survey examined family characteristics, physical health and nutritional status, emotional health, unintentional injuries, drug and alcohol usage, sexual relationships, and academic performance. It is important to note that fifty-three percent of the total sample was taken from one tribal group. In addition, the sample (13,454) is less than ten percent of the estimated total (165,659) American Indian and Alaska Native students in the 33 states where IHS has health care responsibilities.

The information generated from the survey was especially useful for local IHS health care providers and Tribal workers. The University of Minnesota was very sensitive to this local need and sent tabulated data to the IHS areas and service units that were involved in the survey and, when requested, provided data to local professionals for direct analysis.

In four IHS areas, one-half to one day conferences--which included Tribal participation, IHS and BIA professionals, and adolescents--were held to review and discuss the initial results of the survey. This gave an opportunity for the local IHS and Tribal health workers to begin work on program development. Some of these communities have indicated a desire to repeat the survey locally in order to evaluate the effectiveness of their program efforts.

Injuries/Substance Abuse. The death rate for Native American teenagers is twice that of adolescents of other racial and ethnic backgrounds. For Native American males and females alike, early usage of alcohol and other drugs parallels that of other adolescents. However, starting in the ninth grade, use begins to skyrocket among Native males. By the ninth grade, alcohol use is double that of seventh grade; by 11th grade, it is triple; and by the 12th grade, just over ten percent (one-quarter of those who drink) can be identified as potential problem drinkers.

"There is a clear window of opportunity for health providers and educators to intervene in the early years, say in the sixth, seventh or eighth grade," said Michael Resnick, Ph.D., Director of Research for the Adolescent Health Program at the University of Minnesota. "Success in reducing male drug and alcohol use will lower every other major cause of mortality for Native youth."

Health Problems. An alarming number of the youth surveyed are at high risk for health problems as adults due to insufficient exercise, use of tobacco, and diets high in fat and cholesterol. "We should not take any low self-assessed health status of Native American youth lightly," said Blum, "particularly because of the strong interrelationship between poor health and other adverse outcomes like substance abuse, suicide attempts, and other risk behaviors."

Family and Community Strengths. Findings from the survey suggest that there is considerable strength in the American Indian and Alaska Native family and community. Almost 80 percent say their families care about them a great deal and many would go to a family member first for help. These positive strengths must be used to reduce the unhealthy outcomes that result from disturbing data such as the prevalence of loss of a family member or fear of loss. It is especially important for the IHS to work in partnership with communities in seeking ways to meet the more acute needs of the relatively small but critically important group of youth who are at highest risk.

In addition to support from the Indian Health Service, other funding was provided by the Maternal and Child Health Bureau (a branch of the U.S. Public Health

Service), and the Robert Wood Johnson Foundation. (Reprinted from Tribal Activities Bulletin, Volume 1, Issue 3, Spring 1992)

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"COMPREHENSIVE INDIAN FETAL ALCOHOL SYNDROME PREVENTION AND TREATMENT ACT"
(H.R. 1322)

On March 5, 1992, the Committee on Interior and Insular Affairs held a hearing on H.R. 1322, "Comprehensive Indian Fetal Alcohol Syndrome Prevention and Treatment Act." The hearing was chaired by both Rep. George Miller, California, and Rep. Ben Nighthorse Campbell, Colorado. Testifying for IHS were Mr. Michael Lincoln, Deputy Director, IHS, and George Brenneman, M.D., Coordinator, Maternal and Child Health, IHS. The IHS took a neutral position on the legislation and testified that the authority already exists to accomplish the goals of H.R. 1322. (Reprinted from Tribal Activities Bulletin, Volume 1, Issue 3, Spring 1992)

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PRESIDENT BUSH ISSUES PROCLAMATION: YEAR OF THE AMERICAN INDIAN, 1992

President Bush issued the following proclamation March 2, designating 1992 as the Year of the American Indian.

Half a millennium ago, when European explorers amazed their compatriots with stories of a New World, what they actually described was a land that had long been populated by numerous, complex societies. Each tribe formed a thriving community with its own customs, traditions, and system of social order.

The contributions that Native Americans have made to our Nation's history and culture are as numerous and varied as the tribes themselves. Over the years, they have added to their ancient wealth of art and folklore a rich legacy of service and achievement. Today we gratefully recall Native Americans who helped the early European settlers to survive in a strange new land; we salute the Navajo Code Talkers of World War II and all those Native Americans who have distinguished themselves in service to our country; and we remember those men and women ofIndian descent -- such as the great athlete, Jim Thorpe and our 31st Vice President, Charles Curtis -- who have instilled pride in others by reaching the heights of their respective fields. We also celebrate, with special admiration and gratitude, another enduring legacy of Native Americans: their close attachment to the land and their exemplary stewardship of its natural resources. In virtually every realm of our national life, the contributions of America's original inhabitants and their descendants continue.

During 1992, we will honor this country's native peoples as vital participants in the history of the United States. This year gives us the opportunity to recognize the special place that Native Americans hold in our society, to affirm the right of
Indian tribes to exist as sovereign entities, and to seek greater mutual understanding and trust. Therefore, we gratefully salute all American Indians, expressing our support for tribal self-determination and assisting with efforts to celebrate and preserve each tribe's unique cultural heritage.

The Congress, by Public Law 102-188, has designated 1992 as the "Year of the American Indian" and has authorized and requested the President to issue a proclamation in observance of this year.

Now, therefore, I George Bush, President of the United States of America, do hereby proclaim 1992 as the Year of the American Indian. I encourage Federal, State, and local government officials, interested groups and organizations, and the people of the United States to observe this year with appropriate programs, ceremonies, and activities.

In witness whereof, I have hereunto set my hand this second day of March, in the year of our Lord nineteen hundred and ninety-two, and of the Independence of the United States of America the two hundred and sixteenth.

(signed) George Bush

LETTERS

On February 11, 1992, Dr. Frederick K. Goodwin, administrator of the Alcohol, Drug Abuse and Mental Health Administration, met with the Advisory Council on Mental Health. During a discussion of urban violence and studies showing its relationship to drug and alcohol abuse, Dr. Goodwin made a statement in which he compared violence by inner city youths to the behavior of "male monkeys" in the jungle. Because of his comment Dr. Goodwin resigned from ADAMHA but was given the Directorship of the National Institute on Mental Health.

Specifically, Dr. Goodwin said: "If you look, for example, at male monkeys, especially in the wild, approximately half of them survive to adulthood. The other half die by violence. That is the natural way of it for males, to knock each other off and, if fact, there are some interesting evolutionary implications of that because the same hyperagressive monkeys who kill each other are also hypersexual, so they copulate more and therefore they reproduce more to offset the fact that half of them are dying. Now, one could say that if some of the loss of social structure in this society, and particularly within the high impact inner-city areas, has removed some of the civilizing evoluationary things that we have built up and that maybe it isn't just the careless use of the word when people call certain areas of certain cities jungles ..."

Paul Dauphinais, Ph.D., the President of the Society of Indian Psychologists, wrote a letter to Louis W. Sullivan, M.D., Secretary of the Department of Health and Human Services. The letter states that Dr. Goodwin's remarks reflect an insensitivity to people of color, and are an inappropriate and inaccurate extrapolation from existing primate research. On behalf of SIP, Dr. Dauphinais expressed opposition to Dr. Goodwin's appointment as Director of NIMH. Dr. Sullivan's response is reprinted as follows:

April 13, 1992

Dear Dr. Dauphinais:

The President has accepted Dr. Goodwin's resignation as director of the Alcohol, Drug Abuse, and Mental Health Administration. He will now serve as director of the National Institute of Mental Health.

Dr. Goodwin's remarks on February 11 were an unfortunate lapse in a career of public service otherwise characterized by professionalism of the highest quality and sensitivity to minority issues. I retain complete confidence in Dr. Goodwin's scientific integrity and commitment to equality.

I consider this issue closed and believe appropriate and sufficient actions have been taken. We need to now move forward with the mission of ADAMHA. I soon will be announcing a candidate for that agency and believe that the highest standards of professionalism, leadership, scientific integrity and sensitivity will be met by that nominee.

Sincerely,

Louis W. Sullivan, M.D.
Secretary of Health and Human Services

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October 29, 1991

Dear Colleagues:

Brian Wilcox of APA informs me that scholarships are available for American Indians through Federal funds. However, although psychology students are now eligible, the physicians have been controlling distribution. Letters to our congress persons would help.

Sincerely,

Richard M. Suinn
Professor and Head
Department of Psychology
Colorado State University
Fort Collins, CO 80523

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October 22, 1991

Dear Colleagues:

We are pleased to inform you about our book, A Gathering of Wisdoms; Tribal Mental Health: A Cultural Perspective. This book presents the ideas and experiences of an unusual Tribal Mental Health Program which has been cooperatively developed and operated by the Swinomish and Upper Skagit Tribes along with Skagit Community Mental Health

Center since 1984. The goal of this program has been to provide culturally specific services to Indian clients, and to develop a culturally congruent model for tribal mental health service delivery.

In 1988-89 special federal funding allowed us to share our experiences and program model through a series of Inter-Tribal/Inter-Agency Tribal Mental Health conferences and through the development and distribution of the Swinomish Tribal Mental Health Booklets.

Recent financial support from both the Portland Area of the Indian Health Service and from the Washington State Division of Mental Health has allowed us to reprint this material in this single volume book, A Gathering of Wisdoms. Copies of this book may be purchased for $16.95 each (add $3.00 per book for postage) from the Swinomish Tribal Community, P.O. Box 388, LaConner, WA 98257.

This title reflects the collaborative nature of our project and the mutual respect which has developed between Traditional Indian Elders, Tribal mental health workers and community mental health professionals. We hope that you will find it useful in providing services to Indian people. We hope our small contribution in documenting and encouraging culture-specific approaches to serving Native American as well as other ethnic-minority clients helps you.

We would appreciate hearing your comments about this material, as well as receiving information or copies of any ethnic mental health materials you may have developed. Please direct questions or correspondence to Jennifer Clarke, Ph.D., Tribal Mental Health Program Director, (206) 466-7232.

Sincerely, Swinomish Tribal Community

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March 3, 1992

Dear Colleagues:

We are in the process of completing the 1992 directory of American Indian and Alaska Native (AI/AN) Professors. We anticipate that the directory will become a resource for networking AI/AN professors, referring interested parties to professors in specific academic disciplines, and assisting in job searches specifying AI/AN preferences. Our directory currently includes 275 names, and we are pleased to provide such an extensive and comprehensive listing.

If you have already completed an information form for this directory, please contact us so that we may send you one. We are sensitive to the fact that some people might not wish to have their name included in a public listing. If you would prefer to be left out of the directory to be distributed, please check the appropriate box on the form.

We look forward to sharing our completed directory with you.

Sincerely, Dr. Karen Swisher, Coordinator
Center for Indian Education
Arizona State University, 415 Farmer
Tempe, AZ 85257-1311

PROFESSIONAL MEETINGS

5TH ANNUAL CONVENTION OF
AMERICAN INDIAN PSYCHOLOGISTS AND
PSYCHOLOGY GRADUATE STUDENTS

The Utah State University Psychology Department and Indian Health Service are co-sponsoring the 5th Annual Convention of American Indian Psychologists and Psychology Graduate Students to be held at Utah State University, Logan, Utah on July 20-21. The Bear Lake Retreat will be held Friday, July 17 at 5:00 pm through Sunday, July 19. The Bear Lake Retreat Center will be available for housing Sunday and Monday nights, July 19 and 20. Vans will be available to provide transportation to and from Bear Lake for those who need it.

The opening group discussions on July 20 and 21 will center on the following questions: "Is there a need for an American Indian Psychology?" and "If so, how can we begin to develop a psychology specific to the needs of American Indians?" These discussions will be facilitated by Patricia Tswelnaldin and Ed Duran.

For more information, call Carolyn Barcus, Ed.D., Project Director, American Indian Support Project, Department of Psychology, Utah State University. The telephone number is (801) 750-1460.

PROFESSIONAL OPPORTUNITIES

Director of Mental Health, Mental Retardation, and Substance Abuse Services. Arlington County, Virginia (170,936 population urban area adjacent to Washington, D.C.) seeks senior-level public administrator with background in human services/mental health field to direct comprehensive integrated services involving mental health, mental retardation and substance abuse. MPA or related graduate degree required. Excellent interpersonal and oral/written communication skills essential. Ability to direct professionals in services to a multicultural/multi-ethnic, mixed socio-economic community required. Superior administrative and financial management background required; position responsible for 150 FTE staff and $12.5 million budget. Anticipated salary range $60,000-$82,000 with excellent benefits. Apply at once in complete confidence: Paul A. Reaume, The PAR Group - Paul A. Reaume, Ltd., 100 North Waukegan Road, Suite 200, Lake Bluff, IL 60044. TEL: 708-234-0005; FAX: 708-234-8309.

Licensed Clinical Psychologist. The Counseling Service, Stone Center for Developmental Services and Studies seeks psychologist interested in working with the perspective on women's relational development that is evolving at the Stone Center. The Counseling Service provides support to the Wellesley College community which is quite diverse. Experience in short-term counseling with college age women and in outreach programming to special populations, i.e., Latina or Asian, is desirable. Position is half-time (17.5 hours/week) for the duration of the academic year (9 months). Benefits are included. Interested persons send resume and cover letter to: Patricia Basque, Personnel Office, Wellesley College, 106 Central Street, Wellesley, MA 02181 by JUNE 15, 1992.

Psychology Instructor. NVIT invites applicants for Psychology Instructor for 1992-93 academic year to teach Introductory Psychology and courses in two or more of the following areas: experimental; behavior disorders; developmental; brain and behavior; motivation; and clinical. Psychology courses provide basic academic grounding for NVIT Social Welfare degree program as well as prepare psychology major students for two years of university transfer credits. Successful candidate will have at least Master's degree in Psychology; some teaching and counselling experience; preferably has done further graduate work in psychology or related fields. Knowledge of First Nations issues and experience working with Aboriginal Peoples are assets. Floor salary: $40,000 per annum subject to budget constraints. NVIT is an equal opportunity institution. First Nations candidates are especially encouraged to apply. Send curriculum vitae; arrange to have at least two confidential letters of reference sent directly to Janet Simpson-Cooke, Nicola Valley Institute of Technology, Box 399, Berrit, B.C. VOK-2BO without any delay. Date of appointment: mid-August, 1992. Closing date of applications: Until position filled. NVIT telephone (604) 378-2251; FAX (604) 378-5898.

International Education Development. Teachers College, Columbia University. Senior Assistant/Associate Professor, Two-year appointment, renewable and tenurable. The Division of Philosophy and the Social Sciences is seeking a scholar/practitioner with demonstrated experience in international and/or comparative education, and an emphasis on the application of education to programs of social and economic development. Candidates may have a degree in social science (anthropology, economics, sociology, etc.) or in a professional field of interest (Africa, Europe, Latin America, etc.) is (business, education, health, etc.); geographical area open. RESPONSIBILITIES: Direct graduate program in international education development; provide instruction and supervision of doctoral students; advise and support faculty and students in international and comparative education issues; act as a liaison with research centers and cooperating departments and programs of the College. QUALIFICATIONS: Ph.D. or Ed.D. required. Review of applications will begin April 15, 1992, and will continue until the search is successfully completed. Send letter of application, CV and a list of three references to: IED Search Committee, Box 211, Teachers College, Columbia University, 525 West 120th Street, NY, NY 10027. Applicants are invited to send a sample of relevant publications.

AFFIRMATIVE ACTION REGISTER

Each month, the Society of Indian Psychologists receives the Affirmative Action Register, the only national EEO recruitment publication directed to females, minorities, veterans, and handicapped. Each month approximately 175 advertisements appear for administrative, managerial, and professional positions. For a free subscription write: Affirmative Action Register, 8356 Olive Boulevard, St. Louis, MO 63132, or telephone (314) 991-1335, or (800) 537-0655.

NEWSLETTER PRODUCTION

The Society of Indian Psychologists Newsletter is the official publication of the Society of Indian Psychologists, and is published two times per year.

The Newsletter is mailed to all members of the Society of Indian Psychologists. News items, articles, announcements, letters to the editor, etc. should be typewritten and double spaced. Deadlines are: October 15 for the Winter Issue, April 15 for the Summer Issue. Send to:

Glenn W. Humphrey
207 W. 96th Street
New York, NY 10025

STATEMENT OF AIMS AND OBJECTIVES

The aims and purposes of the Society of Indian Psychologists includes but not limited to the operation of a national body organized for non-profit, charitable, and professional purposes; to provide an organization for Indian and Native peoples who are vitally concerned with improving the mental well-being of their people; to create, through an exchange of skills, expertise and experiences, opportunities for career development, positive inter-and intra-personal relationships, and general personal enhancement of Indian and Native peoples; to encourage all Indian and Native people to become involved in improving the quality of their lives.

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To apply for membership in the Society of Indian Psychologists or renew your membership, please provide the following information:

Name: _____
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Are you a student? ( ) Yes ( ) No If yes, major field of study: _____
Institution attending: _____ Degree seeking: _____
Other Professional Memberships: _____

Please enclose check payable to the **Society of Indian Psychologists,**
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SIP NEWSLETTER
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