Society for the Psychological Study
Of Culture, Ethnicity and Race
DIVISION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

PRESIDENT'S COLUMN - ROYLEEN J. ROSS

Gu wa zee Ho bah! As my time serving as your Division 45 president is nearing an end, I will close wishing all a blessed holiday season. This edition will include messages from President-elect Fred Millan, Past president Helen Hsu, EC member introductions, an article on Native Health Equity, and interviews with CDEMP editors. MMXXIV (2024) has been a busy year with dichotomous unexpected events and predictable outcomes. As I write from one of the Pueblo tribal lands that has been in existence since time immemorial, I will iterate a message sent earlier in the month by the Trio: "In the current spaces we hold, it is important to remember that the work we do is more important than ever. Many of our ancestors were silenced during challenging times, but it is with their strength that we continue to endure. We remain united and resolute, as we fight to impact positive change for our communities. It is through our community that we can find solace, support, resources, and cumulative strength to continue our advocacy and care work." Our solidarity matters.

November is observed as National Native American Heritage Month in the United States. In his proclamation, President Joseph Biden stated, "Indigenous peoples' history in the United States is defined by strength, survival, and a deep commitment to and pride in their heritage, right to self-governance, and ways of life. Native peoples have built and sustained powerful Tribal Nations, and the knowledge they developed still benefits us today… Indigenous peoples have persisted and survived — a testament to their resilience and resolve." While the sentiment is appreciated, including an acknowledgment that Indigenous Peoples are resilient, our Pueblos, tribes and nations continue to work toward equity and parity in many sociopolitical arenas. Health disparities remain rampant; all of our ethnic populations and communities are impacted.

Though at times it feels as if defeat is only a short distance away, together we are stronger working toward equity and a just society. As I visualize our work, I relate it to running a marathon with surmounting challenges at each mile (I have run at least two marathons annually in recent years). And at mile 15 or 18 or 20 or 23, hitting "the wall" can be excruciating and gut wrenching, but through perseverance, determination, and sometimes pure exasperation, the hope of the marathon completion is possible. Prayer, strategy, and the training knowledge the muscles have gained are the foundation as so many things can go wrong. At times our work feels like we hit the wall, but we persevere. "We need each other now more than ever!"

Earlier in the month Division 45 hosted a webinar on food insecurity. A panel of remarkable experts, Dr. Luz M. Garcini, Dr. Stephen Gillapsy, Dr. Yu-Wei Wang, Mr. Perry M. Martinez, and Ms. Monika Lacka, discussed various perspectives on food insecurity. It is a topic often shelved but the impacts to individuals, families, and communities are vast. In December, a webinar will feature the work of the Division 35/45 Missing and Murdered Indigenous Relatives Task Force. Recently I have conducted work with a historic boarding school entity. The intent of boarding schools was to break the cohesiveness of Native families; many Native children were involuntarily removed from their families and tribal communities. At my place in life, I am re-examining my upbringing as I am a direct descendant of boarding school grandparents and great-grandparents. I would encourage the reading of the Federal Indian Boarding School Initiative Investigative Reports. Research is both available and emerging that correlate systemic boarding school environments with the medical and social maladies afflicting descendants, family dynamics, and that are present in contemporary Native communities.

I would like to extend my deepest gratitude to Fred and Helen for leading with me collectively. I am also thankful for the Division 45 EC for all of your support an work throughout my presidency. I am appreciative of the APA convention programming team, including Tina Lincourt, Maria Crouch, and Maredyth Cheromiah Salazar, for putting together a solid program. And Dr. Derald Sue and family, thank you for sharing your brother, and allowing us to honor him. As 2025 is upon us, please know I remain in service to you. We are one humanity.

A MESSAGE FROM PAST PRESIDENT HELEN HSU

Division 45 came together in 1986, bringing together our collaborative body of scholars, healers, advocates, and educators. Together, we are a foundational beacon, lead, and shelter in the field of psychology. While we gather under the umbrella goal “the study of culture, race, and ethnicity,” the generosity, wisdom, and genuine connections I have found here are far deeper.

It is remarkable to experience the paths carved out for each generation of our members. When I was a graduate student, there were challenges and barriers to those interested in multicultural psychology. Yet there was also a journal, books, conferences, and leaders within psychology whose work resonated with my core values and interests. I didn’t realize I was randomly fortunate-one of my first professors was Derald Wing Sue. At every step of my journey, I encountered mentors, accomplices, and friends. I was able to live my values serving in community mental health clinics and eventually entered the “volun-told” traditional path into leadership.

These last few years we have all lived through unrelenting “unprecedented times.” I struggle mightily to process the massive scope of losses from the pandemic, racist violence, and genocides. I am keenly aware how many of us are teetering at the margins of despair and burn out as we tend to those suffering and fight to speak truth. It is valuable to honor our sacred rage, our well of grief. Many of us are presently strategizing and steeling ourselves to face looming political attacks on our communities. May we continue to sustain ourselves in joy, community care, and alliances. Poet Ocean Vuong writes of the fierce creativity it takes to survive colonialism and violence.

A term from Indigenous scholars comes to mind: “survivance.” Reading Vizenor’s descriptions of survivance as a dynamic and ongoing refutation of disempowering and erasure narratives, I recognize so many of our interconnected struggles. Beyond merely possessing resilience, we are a people steeped in ancestral strengths and inextinguishable survivance.

Thank you for entrusting me with the honor of this time on the Division 45 executive committee. My Presidential Initiative uplifting rematriation values was inspired by my mujerista elders and the support and inspiration of sister warrior presidents Iva Graywolf and Evie Garcia. The projects, determination and work of the executive committee have been deeply meaningful. To have dreamed, strategized, created, and communed alongside our members and families has been a privilege and honor.

I remain steadfast in my determination to uphold People of the Global Majority values. I am hopeful about the dynamic brilliance of our communities. I am excited for the fresh leaders we meet each year at Links and Shoulders, and our outstanding student committees to mold the division to its future directions. For those newer to the division, I wholeheartedly encourage you to foray into leadership . Our community evolves as you share your wisdom, perspectives, and talents.

It was a perfect fit to shift from my presidency to that of Royleen Ross, a leader who embodies Pueblo matriarchal traditions. I met incoming president Fred Millan when we both focused on updating the ethics codes of APA utilizing the values and traditions of ethnic psychological associations. Division 45 is in skilled and ethical hands for the journey ahead.

A TIME TO STAND UP AND STAND TOGETHER: A LETTER FROM PRESIDENT ELECT FRED MILLAN

Dear Colleagues,

As incoming president for Division 45, the Society of Psychological Study of Culture, Ethnicity and Race, I know many of you share my concerns about what the new year and changes in administration in Washington, DC will bring for us, our work and, most importantly, our communities. There will be many challenges to our worldview, to our dignity and, in many ways, to our very existence.

As an academic, I bristle at the attempts to erase our perspectives and histories from the curriculum and creating environments that feel unwelcoming and unsafe for our students. As a clinician, I see the pain, anxiety and depression my clients experience in a world in which many are overtly disparaged. As a parent, I worry about my children walking in this world in their skin, their queerness and their uniqueness. As a Puerto Rican man who has been in these fights for a long time, I recognize and processed my own sadness, fear, frustration, anger and disappointment that we're back here today, that what we have collectively worked for is threatened.

Despite these challenges, I am resolute and confident in our capacity to continue to fight and to thrive. I know many of you feel the same way. Our communities have long histories of overcoming adversity and oppression. We have a wealth of historical and ancestral resilience, courage, and wisdom to build on. We are diverse and evolving within and between our respective communities. We are the past, present and future. Let's work to be inclusive and really celebrate all our intersectional glory! Let's commit to honest dialogue and staying at the table to process with each other when we disagree or our interests are not clearly aligned. Let's find common ground to harness our collective power and provide support for each other when times get hard.

Please take care of yourselves, whatever form that takes for you. We'll need our stamina for the long-haul process. Look out for and reach out a hand to those struggling. Our commitment to advocacy for the disenfranchised is unwavering. We're all in it together.

Division 45 invites and welcomes ideas for collaboration and support as we navigate these stormy times together. In this spirit, our 2025 convention theme will be "Building Effective Coalitions for Leadership, Care and Advocacy." Throughout the year we will provide programming and spaces for discussion, strategizing and collaboration to advocate for the needs of our communities.

We are a division of survivors, of thrivers… of leaders. Let's continue our work for our students, clients, families and communities. It is a time for us to stand up and stand together!

Pa'lante juntos,

Fred Millán, PhD, ABPP, NCC

COUNCIL REPRESENTATIVE SHERRY WANG

Sherry C. Wang, PhD, is an Associate Professor of Counseling Psychology at Santa Clara University. She is a licensed psychologist, researcher, and anti-racist educator. She identifies as a cisgender woman (she/her) and her worldview is influenced by her bilingual and bicultural background as a Taiwanese immigrant and Asian American. Her scholarship is rooted in advocating for the voices of BIPOC (Black, Indigenous, People of Color) communities and she focuses on the ways in which sociocultural determinants (e.g., access to healthcare services, social support, community attitudes) contribute to ethnic/racial health disparities. She sees patients one day a week and teaches graduate courses in multicultural counseling, developmental psychology, counseling theories, microskills, and feminist multi-cultural therapy. She chairs the Asian American Psychological Association (AAPA) Division on Women (DOW). She has chaired the American Psychological Association (APA) Committee on Ethnic Minority Affairs, which is a 6-member committee responsible for addressing issues that pertain to culture, ethnicity, and race. She was previously part of APA's Committee on Psychology and AIDS, which has since been expanded and renamed as a committee on health disparities. She currently serves on the American Psychological Association (APA) Council of Representatives, as a representative for Division 45. Since the start of COVID19, she has been featured, cited, and interviewed in the media on the topic of anti-Asian racism, xenophobia, and cross-racial coalition-building.

TREASURER TOMAS GRANADOS

Dr. Tomas Granados has served as Treasurer of the APA Division 45 as of January 2023. He is in a neuropsychology private practice in Albuquerque, New Mexico. A large part of his practice consists of evaluation and treatment of monolingual Spanish speaking recent immigrants from Latin American countries. Dr. Granados has been in clinical practice in New Mexico for 28 years. He is Past President of the Association of State and Provincial Psychology Boards (ASPPB) Board of Directors, Former Chair of the ASPPB Equity and Inclusion Task Force, Former Chair of the New Mexico Board of Psychologist Examiners (NMBPE), current Co-Chair of the NMBPE Rules Committee, Member of the New Mexico Legislative Healthcare Workforce Committee, and Member of the New Mexico Workers Compensation Administration Medical Advisory Committee. Dr. Granados lives in Albuquerque, NM with his wife. He and his wife have 2 young adult daughters. Their older daughter Marisa, lives in Seattle, WA and their younger daughter, Analise, is in her 4th year of college at Oberlin College and Conservatory in Ohio. Marisa recently joined Division 45! Dr. Granados is very pleased to provide support to the efforts of the many talented Division 45 Executive Committee members and Division 45 membership. He is humbled by the impressive creativity and energy of this vibrant group of professionals who have worked diligently and tirelessly for many years to achieve greater equity and inclusion within the broader psychology community and in our respective communities.

MEMBERSHIP CHAIR STEVEN STONE-SABALI

Hello! I am Steven Stone-Sabali, and I currently serve as the Membership Chair for APA Division 45. I was born and raised in Philadelphia, PA, and trained as a Counseling Psychologist. I am now an assistant professor at Ohio State University, where I continue my passion for supporting minoritized communities, a journey that started over 20 years ago when I first worked with at-risk youth. Much of my current work focuses on teaching the next generation of practitioners to be culturally and racially informed, as well as researching factors that promote the well-being of Black individuals and processes that enhance their interactions with non-Black, such as the Racial Rupture and Repair Process. With these passions and experiences, it is no surprise that APA Division 45 feels like a second home to me. I am truly grateful for the opportunity to support both this incredible community and the organization as a whole.

PASIFKA/PACIFIC ISLAND MEMBER AT LARGE GE KAWIKA ALLEN

Professor Allen received his Bachelors degree in speech/organizational communication and his Masters degree in counseling psychology at the University of Utah. He then received his PhD in counseling psychology from the University of Missouri-Columbia (a top-ranked program) and completed his predoctoral clinical internship at Duke University. His research areas involve spiritual, cultural, and Indigenous ways of healing in psychotherapy, including culturally appropriate psychotherapies and interventions for underserved populations. Professor Allen also conducts research related to religiosity, perfectionism, scrupulosity, and psychological wellbeing among various diverse populations. In addition, Professor Allen has focused much of his research on culture-specific counseling interventions and the intersections of religiosity/spirituality, coping/collectivistic coping, depression, anxiety, and psychological well-being/adjustment among Polynesians/Polynesian Americans. Professor Allen is the founder of and leads the Polynesian Psychology Education Research Team (The Poly Psi Team) research efforts involving not only Polynesian/Pasifika Psychology Research, but research across various underrepresented populations. Dr. Allen has traveled with his colleagues and students across the South Pacific, including New Zealand (Aotearoa), American Samoa, Hawaii, and Fiji conducting spiritual, cultural, and indigenous interventions in psychotherapy for psychological healing among Pacific Islanders/Pasifika. He was recently awarded a Fulbright Specialist Scholarship teaching, providing training, and presenting and conducting research at a university in Brazil. He has numerous publications in top-tier scientific journals, over 4 million dollars in research grants, and multiple professional presentations at national and international conferences. Early in his career, Professor Allen was nominated and elected Early Career Professional of the American Psychological Association (APA) Division 36: Society for the Psychology of Religion and Spirituality, a newly created position. Dr. Allen was also appointed Member-at-Large (MAL), Pacific Islander Slate for APA Division 45, which was also a new slate position created for the Pacific Islander population. He has held editorial board and leadership positions in Divisions 17, 36, and 45 of the American Psychological Association. Dr. Allen is an associate professor in the PhD program of counseling psychology at Brigham Young University. He and his wife, Carolina, have 7 children and they live in Provo, Utah.

EARLY CAREER MEMBER AT LARGE YARA MEKAWI

Dr. Yara Mekawi is an assistant professor in the Department of Psychological and Brain Sciences at the University of Louisville and a licensed clinical psychologist. She completed her bachelor degree in psychology at the University of Illinois Chicago and her doctorate in clinical and community psychology at the University of Illinois at Urbana-Champaign after completing her internship at the Emory School of Medicine. She is the director of the Challenging Ongoing Legacies Of Racism (COLOR) lab and her research focuses on examining racism at the intersection of affect and cognition. Using interdisciplinary and multi-method approaches, she pursues three main lines of inquiry: (a) What are the cognitive and affective mechanisms through which race-related stress is associated with psychopathology in racially marginalized groups? (b) What are the cognitive and affective factors that maintain racially-prejudiced behavior and attitudes among White individuals? and (c) What are the most effective strategies to reduce racial prejudice and ameliorate its effects on the mental health of individuals from racially marginalized groups? Dr. Mekawi is interested in the assessment and integration of DEI practices within psychology programs and the implementation of interventions designed to increase belonging for individuals from marginalized groups. She is also a co-founder of the Dialectical Engagement in Anti-Racism (DEAR) project which provides anti-racism trainings and resources to White allies.

LGBTQ OF COLOR MEMBER AT LARGE ROBERTO ABREU

Dr. Roberto L. Abreu is an Associate Professor, Colonel Allen R. and Margaret G. Crow Term Professor, and the director of the Collective Healing and Empowering VoicEs through Research and Engagement (¡Chévere!) at the University of Florida, Department of Psychology. His research program focuses on the relational and systemic experiences and mental health outcomes among LGBTQ youth and their families and communities, with a focus on Latinx LGBTQ youth and transgender and gender diverse (TGD) youth. Other areas of research include LGBTQ adults experiences of discrimination, oppression, violence, resilience, and joy. Dr. Abreu has served as Co-Investigator (Co-I) and Multiple Principal Investigator (MPI) in multiple national grants (totaling over $16 million across projects), including active funding from the National Institute of Health (NIH), Community Partnerships Advance for Science (ComPASS; 1OT2 OD035935-01) and NIH Research Project Grant Program (R01; 1R01MD019678-01). Roberto has published over 80 peer-reviewed articles and book chapters and has co-edited two books- LGBTQ+ Affirmative Psychological Interventions: A Latinx Perspective (Springer) and Affirming LGBTQ+ Students in Higher Education (APA publisher). Roberto currently serves as Associate Editor for Psychology of Sexual Orientation of Gender Diversity (PSOGD); Cultural Diversity & Ethnic Minority Psychology (CDEMP); Journal of Prevention and Health Promotion (JPHP); and Qualitative Psychology (QP).

GRADUATE STUDENT REPRESENTATIVE EBONI MARTIN JONES

Eboni Martin Jones, MA, MEd, is from Los Angeles, CA. She completed her bachelor degree in psychology with a minor in child development from San Diego State University. She also received masters degrees in educational counseling and psychology from the University of Southern California and Loma Linda University, respectively. She is currently pursuing her PhD in clinical psychology with a concentration in health and primary care psychology at Loma Linda University (LLU). Her research focuses on the relationship between trauma (including racial trauma) and Tobacco Use Disorders. At present, she serves as the American Psychological Association (APA), Division 45, Society for the Psychological Study of Culture, Ethnicity, Student Representative. She is also a recipient of the APA Interdisciplinary Minority Fellowship (IMFP) and the LLU 4P Primary Care Psychology Pipeline Program Scholarship.

NATIONAL MULTICULTURAL SUMMIT CO-CHAIR SAMANTHA LAMARTINE

Samantha LaMartine is a clinical psychologist and assistant professor of psychiatry at the Chobanian and Avedisian School of Medicine, and she serves as the Director of Psychological Services for the Wellness and Recovery after Psychosis (WRAP) clinic at Boston Medical Center. Her clinical interests include health psychology, empowering patients to understand the impact of their behaviors, thoughts, and emotions on their physical health. Dr. LaMartine is also deeply committed to early psychosis intervention for young adults, focusing on early identification to improve long-term outcomes. Her research and teaching emphasize mental health disparities, with a particular focus on how systemic issues such as racism and discrimination affect access to quality care for intentionally underserved communities. She served as the 2023 Convention Co-chair for the APA Division 45 Conference and more recently served as a Committee Member for the 2024 APA Conference.

AMERICAN INDIAN AND ALASKA NATIVE HEALTH EQUITY

IVA GREYWOLF, LEMYRA DEBRUYN, AND ROYLEEN J. ROSS

INTRODUCTION

American Indian and Alaska Natives (AIAN) have a legal right to healthcare from the US government due to the forced relocation or land exchanges of AIAN tribes throughout American history (Brayboy & Chin, 2020; Ross et al., 2020; Warne, Kaur, & Perdue, 2012). It is a common assumption that this codified relationship guarantees access to quality healthcare, and that AIAN have the status and health outcomes comparable to other racial/ethnic groups. The misconception of free superior healthcare provided to AIAN underlies the basic need for health equity.

AIAN have been remarkably resilient in the face of systemic oppression across generations. However, disparities in health status are significant and access to care is a chronic challenge. The Indian Health Service (IHS), responsible for providing AIAN healthcare, is one of the most critically underfunded agencies in the federal government (McDonald and Chaney, 2013; McDonald et al., 2019). Despite the legal obligation to provide healthcare for AIAN, the US government provides less than 40% of the equivalent US per capita healthcare expenditures, totaling approximately $4078 per person/year (Warne, 2021), and the agency regularly runs out of funds before the end of the fiscal year (Warne et al., 2012). The failure to meet the health needs of AIAN people is a centuries-long pattern resulting in severe and systemic health disparities.

In the 2020 census, over 2.3 million US citizens identified as AIAN only and, in any combination, more than 6 million identified as AIAN (United States Census Bureau, 2023). Despite AIAN being the third-largest minority group in the US, AIAN health is significantly omitted from broader health equity discussions, and the amount of literature addressing AIAN health is not commensurate with the size of the AIAN population. The context and resulting legacy of historical atrocities committed against AIAN people demand far greater scrutiny when discussing AIAN health equity. Similarly, the remarkable capacity of AIAN Peoples to thrive amidst the inequities of historical trauma demonstrates how cultural resilience promotes AIAN health equity.

The mistreatment of AIAN Peoples has been severe and systemic: massacres, theft of land, forced removal of children to government boarding schools, involuntary adoptions outside of Native families, repeated breaking of forced treaties, and numerous medical injustices. These injustices are not only historical, they are enduring and perpetuate inherent mistrust. In the 1970s the US government sterilized thousands of AIAN women without their knowledge. It is estimated that IHS sterilized 25-50% of all AIAN women of childbearing age in the early 1970s (Lawrence, 2000; Minthorn, 2018). Convictions and sentencing of IHS physicians for sexual abuse of AIAN children/adolescents only added to the ongoing distrust (Weaver & Frosch, 2020; US Department of Justice, 2021).

Since 1975, some tribes have elected to establish their own tribal clinics and hospitals as an alternative to services provided at IHS, due to the passage of the Indian Self-Determination and Education Assistance Act (ISDAA), otherwise known as PL 93-638. ISDEAA placed control of health services into the hands of tribes (Warne et al., 2012). While these services are most frequently on reservations, Urban Indian Health Centers/Urban Indian Organizations are operated in 45 locations in 21 states (National Council of Urban Indian Health, 2019).

A key factor that complicates AIAN health equity work is a prevailing misunderstanding of the composition of the AIAN population. While all AIAN groups share a common history of persecution, the AIAN population is not a monolithic group: as of January 2024 there are 574 federally recognized tribes across 35 states, each with its own unique culture that intersects with underlying factors impacting health equity. Findings in one sample may not translate to another sample, not because of limitations in design, but due to fundamental differences between the groups being considered. Recognizing and taking into consideration the types of diversity within the AIAN population is critical to truly advancing the field of AIAN health equity. Often, in order to achieve adequate sample size for many studies, recruitment must occur across tribes and/or reservations within a tribe, which can complicate interpretation of findings (Verney et al., 2015) and impacts external validity of the studies (Greenfield & Venner, 2012; Whitbeck, Walls, & Welch, 2012).

Another complicator in studying AIAN health equity is the separation between remote, rural and urban AIAN groups. There is widespread misperception that AIAN populations are rural residing. While AIAN are the only racial/ethnic group in the United States that has a higher representation in rural than urban areas, estimates indicate approximately 78% - 87% are urban (Indian Health Service, n.d.).

Finally, the lack of literature to adequately describe the health needs of reservation-residing, rural non-reservation residing, and urban-residing AIAN populations is a paramount issue. Even within rural residing AIAN communities, diversity is overlooked. Many AIAN live in difficult to access remote/frontier locations without a road system, accessible only by plane, boat, or snow machine in the winter. Such locations, dramatically underrepresented in the research literature, present unique considerations for pursuing AIAN health equity.

Despite limitations, the literature supports the presence of serious health disparities that deserve higher levels of attention in health equity. AIAN populations share many types of risk, including sociodemographic and historical. At the sociodemographic level, the AIAN population still represents less than one percent of obtained college degrees (Postsecondary National Policy Institute, 2019), has higher rates of unemployment than the general US population, and faces a markedly increased risk for poverty (Davis et al., 2015). These and other sociodemographic factors are tied to a correspondingly high rate of morbidity and early mortality as outlined by Warne & Lajimodiere in their proposed model of the intergenerational basis for chronic disease disparities (2015).

Historical trauma plays a substantial role in AIAN health disparities. Defined by Brave Heart as “cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma experiences,” historical trauma is the result of the centuries-long to present violence, discrimination, and treachery experienced by AIAN people at the hands of others and the US government. The related Historical Trauma Response posits a constellation of disparities that result from this historical and ongoing oppression, including depression, self-injury, suicide, anxiety, and substance abuse (Brave Heart, 2003; Wiechelt et al., 2012).

The National Atrocity of Boarding Schools

As part of the broader 19th to 20th century attack on AIAN culture and cohesive Native family dynamics to assimilate into the ‘mainstream’, the US government forcibly removed AIAN children (Newland, 2024). By 1930 nearly half of AIAN children were in boarding schools, far from their family and community. Cultural practices and Native language speaking were outlawed, and physical and emotional abuse were the consequences of punishment (Evans-Campbell et al., 2012; Newland, 2022, 2024).) Children were also subjected to psychological abuse, sexual abuse, verbal abuse, maltreatment, malnourishment, forced labor, and involuntary servitude (Newland, 2022, 2024). The federal boarding schools were a system of inadequate sanitation, incubators for infectious disease, violated federal child labor laws, and failed to meet basic physical needs such as food and shelter (NABS, n.d.; Newland, 2022, 2024).The Federal Indian Boarding School reports chronicle the dates of operation between 1819-1969, however boarding schools may have been operational outside these years. The 1969 follow-up report (the “Kennedy Report”) called the boarding school system in its very title “a national tragedy” (Indian Education, 1969).

In concert with tribal healthcare, the landmark 1975 ISDEAA codified the ability of the federal government to make grants and contracts directly with tribes. ISDEAA allowed for the tribes themselves to operate their own educational, medical, law enforcement and other systems. Three years later in 1978, with the passage of the Indian Child Welfare Act (ICWA), AIAN parents finally “gained the legal right to deny their children’s placement in off-reservation schools” (Northern Plains Reservation Aid, 2019). Further, ICWA was instrumental in preventing the involuntary removal and placement of Native children with non-Native guardians. Challenged by various entities since its inception, in 2023 ICWA was upheld by the United States Supreme Court (American Psychological Association, 2023).

Boarding school attendance has been correlated not only to substance use and suicidality in those who attended, but also to increased rates of anxiety, PTSD, and suicidality in their children (NABS, 2019; Evans-Campbell et al., 2012). These outcomes are thoroughly documented in the Federal Indian Boarding School Initiative Investigative Report Vol. II (Newland, 2024). A historic apology for the trauma, abuse, and terror inflicted on children attending boarding schools was issued in October 2024 from the US government (Equal Justice Initiative, 2024). Now, Native communities await meaningful action and reparation, which can contribute to health equity.

OUTCOMES OF FOCUS

Disparities in health status and health outcomes for AIAN populations have been recognized for nearly 500 years (Jones, 2006; Warne, 2021). In 1998, the Adverse Childhood Experiences Study (ACES) chronicled the inter-relationships between childhood experiences and behavioral and chronic disease outcomes (Felitti et al., 1998). ACES are a strong risk predictor for chronic and behavioral health conditions, including heart disease, diabetes, cancer, depression and tobacco use (Warne & Lajimodiere, 2015). This list is also clearly demonstrated in the litany of adverse boarding school outcomes, where children were subjected to atrocities that can appropriately be called Indigenous determinants of health (Riveros, McGlade, & Roth, 2023). To illustrate the interconnectivity of health determinants, we focus on type 2 diabetes in AIAN populations.

Type 2 Diabetes

Type 2 diabetes rates among AIAN populations are higher than any racial/ethnic group in the United States, estimated at up 4 to 8 times the general population (Jiang et al. 2013; Jiang et al, 2018; Sittner, Greenfield, & Walls, 2018).Increased risk for diabetes begins in youth and has increased across the lifespan – for example, AIAN youth 15-19 saw a 68% increase in diabetes prevalence between 1994-2004, and Alaska Native adults saw a more than 2-fold increase from 1985-2006 (Narayanan et al., 2010; Nsiah-Kumi et al., 2013; Satterfield et al., 2016). Morbidity and mortality related to diabetes is higher in the Native population as compared to white counterparts (Jacobs-Wingo et al., 2016). Disparities exist in prognosis and sequelae of diabetes – AIAN adults with diabetes receiving care through IHS have higher rates of hypertension, stroke, kidney failure, amputations, and liver disease than commercially-insured US adults, with morbidity burden exceeding that of non-AIAN groups by 50% (O'Connell et al., 2010). In addition, AIAN women with diabetes who experience discrimination in the healthcare setting are less likely to receive clinically indicated breast exams and pap tests, impacting other health domains even beyond their diabetes (Gonzales et al., 2013).

Risk factors for diabetes in AIAN groups include psychological distress, negative family support, vitamin D insufficiency, a history of trauma, such as ACES, racial microaggressions, and various genetic factors such as genetic markers and shortened telomeres (Brockie et al., 2018; Dill et al., 2016; Goins et al., 2017; Hanson et al., 2014; Nsiah-Kumi et al., 2012; Sittner et al., 2018; Zhao et al., 2014). Medical discrimination plays a significant role in limiting access to supportive care – more than two-thirds of American Indian women with diabetes report having experienced medical discrimination associated with lower rates of dental exams, blood pressure checks, vaccinations, and inadequate glycemic control (Gonzales et al., 2014). Protective factors include cultural spirituality, adherence to traditional diets, and general involvement with traditional tribal culture (Carlson et al., 2017; Dill et al., 2016; McLaughlin, 2010). The diabetes disparity has also been tied to the ways in which the US government institutionalized systems of physical inactivity, high calorie but poor nutrition diets, and psychological distress in their management of reservation systems (Wiedman, 2012). Many tribes attribute diabetes onset to a loss of traditional ways and the external influence of non-AIAN populations (McLaughlin, 2010).

Facilitators to the control of type 2 diabetes identified by AIAN groups in qualitative studies include receipt of culturally relevant diabetes education, social support from peers with diabetes, culture and spirituality, and self-efficacy (Shaw et al., 2013). Barriers include lack of knowledge of nutrition and diet, dietary restriction-related social difficulties, and the impact of comorbid conditions (Shaw et al., 2013) as well as lack of availability of healthy foods due to food deserts and no transportation (Satterfield et al., 2016). Food insecurity also plays a role in food access altogether. From 2000 to 2010, for example, 25% of AIAN families were consistently food insecure, twice that of white families (Jernigan et al., 2017). We suggest subsequent research includes addressing food insecurity as a risk factor for adverse outcomes in disenfranchised populations, including AIANs (Jernigan, et al., 2017).

With respect to national movements, the Diabetes Prevention Program (DPP) has become a leading evidence-based practice in diabetes intervention. While the DPP was developed using Western ideals and normed in non-AIAN populations, AIANs participants were part of the original study (n=171 or about 5%). The IHS Division of Diabetes Treatment and Prevention adapted DPP into the Special Diabetes Program for Indians (SDPI) and implemented it in more than 300 community-driven programs (McLaughlin, 2010). The evidence is mixed regarding the impact of the original DPP on outcomes for AIAN populations. Cultural adaptations of DPP, however, have shown positive changes in weight, blood pressure, and lipid levels (Jiang et al., 2013). The SDPI has continued to demonstrate substantial improvements in health outcomes for AIAN people (Kruse et al., 2022; Indian Health Service, 2020). The incidence of type 2 diabetes among AIAN adults decreased from 15.4% in 2013 to 14.6% in 2017 (Bullock et al., 2017).

Overweight and obesity rates among AIAN children and adolescents aged 2 to 18 years appear to have stabilized in recent years (Bullock et al., 2020).

Other programs include the CBPR-driven Family Education Diabetes Series (Mendenhall et al., 2010), the Traditional Foods Project which combines cultural education with reclamation of traditional food systems (Satterfield et al., 2016), a Medicine Wheel Model of nutrition-based intervention (Kattelmann, Conti, & Ren, 2010), a home-visiting program for AIAN youth with diabetes (Chambers et al., 2015), and a comprehensive K-12 diabetes prevention curriculum that integrates diabetes science with cultural context (Francis & Chino, 2012).
Longitudinal studies have found general improvements in the health status of AIAN populations with diabetes over the past several decades, offering hope that a continued focus on achieving equity in diabetes diagnoses and outcomes can help to eliminate the effects of this striking disparity (Looker et al., 2010).

Culture and Tradition as Medicine

Native Americans have advocated for the integration of traditional healing practices in modern treatment approaches (Gone, 2016; Gone, 2019; Ross et al, 2022). In consideration of this concept, McDonald, et al. stated, “Indian psychology, in context with spiritual and physical healing, has been practiced on this continent for thousands of generations. It is virtually unchanged and springs from the very earth itself” (1993, p. 450-451). Traditional healing is slowly becoming recognized in the western world as having validity in the healing process of AIANs. Traditional healing practices and culturally relevant best practices have been instituted in integrated healthcare settings such as in the IHS (n.d.), the Navajo Nation (Kim & Kwok, 1998), and urban settings including First Nations Community Healthsource (n.d.).

Traditional ceremonies, including healing practices, were outlawed by the US government throughout the boarding school era, and through various federal and state policies until 1978. The penalties for practicing traditionally were harsh, resulting in ceremonies being carried out in secrecy. In 1978, the Indian Religious Freedom Act (AIRFA, 1978) was passed which allowed for the use of ceremonial traditional healing. However, to this day, some ceremonies remain closed to non-Natives and for protective reasons, healing ceremony knowledge is not shared beyond the Native healer, patient, or community.

Contemporarily, Pueblos, tribes, and nations conduct millennium old healing ceremonies. “Native people have their own systems of protection and healing seldom recognized by dominant society” (Ross, et al., 2022). To remedy spiritual and physical ailments, many tribal members seek traditional healing as their primary solution for healing. Daily spiritual practice occurs in all types of environments across the country, not confined to a specified brick and mortar building to practice. To truly advance equity in the AIAN population, traditional healing methodologies and approaches must be recognized as western equivalents to healing. Parity in western science methodologies must also be extended to include Indigenous knowledge (Isaac et al, 2018).

METHODS TO ACHIEVE EQUITY

While there are barriers to achieving health equity for AIAN populations, there is tremendous movement in developing culturally driven methods to do so. Commonly cited barriers for work in the area of AIAN health disparities include mistrust of the research, science, and medical communities, linguistic and cultural disconnects, a lack of culturally grounded approaches, limited/selective access to members of AIAN communities, and a general lack of population-level data on AIAN health (Sarche & Spicer, 2008; Walters & Simoni, 2009).

Discrimination within the healthcare setting remains. Experiences of discrimination have been associated with cardiac events, depression, and hospitalization (Walls et al., 2015). Another obstacle to advancing health equity for AIAN populations are the significant barriers in place for “traditional” educational attainment, including mistrust of educational systems (due to historical oppression – e.g., forced boarding school attendance), disparities in educational quality (Verney et al., 2015), role burdens, marginalization of lines of research inquiry related to AIAN health, and overt discrimination (Walters & Simoni, 2009).

Researchers have identified numerous ways to counteract such barriers to ensure that culturally relevant and community-driven solutions are developed to achieve AIAN health equity. An important movement in recent decades has been an intentional focus on community-based participatory research (CBPR) and other community-academic partnership models (McOliver et al., 2015; Whitesell et al., 2012). This movement entails a paradigm shift:

research is no longer conducted 'on' Native Peoples, but with Native Peoples. Such approaches naturally yield culturally appropriate health education, educational opportunities in the health professions for AIAN, and create natural mentoring programs for AIAN professionals (Eschiti, 2004). Community-driven efforts also lead to integration of and founding in cultural practices (Hawkins, Cummins, & Marlatt, 2004; Legha & Novins, 2012). For non-AIAN researchers, and even for AIAN researchers working with tribes different than their own, it is important to learn about the culture and traditions specific to the tribal community with which partnerships are being built (Mitchell, 2018). It is critical to encourage and facilitate support and involvement of the local community and tribal leaders (McLaughlin, 2010). AIAN health equity experts further recommend an intentional focus on community-level interventions that not only have wider impact, but also help to connect to the broader cultural awareness of community and collaboration often found in AIAN cultures (Tom-Orne, 2014).

Other recommendations for achieving AIAN health equity include use of peer-led programs (Mellanby, Rees, & Tripp, 2000), bicultural competence interventions (McDonald et al, 2018), and the specific inclusion of AIAN lay health educators/community health workers (McLaughlin, 2010) in delivering interventions and programs. Further, there is a strong call for the development of AIAN-specific therapeutic approaches. For example, cognitive behavioral therapy (CBT) with the AIAN population has competing outcomes as being effective (McDonald et al, 2019; McDonald et al., 2018) as well as identified as having a particularly 'western' approach that is not 'culturally relevant' in many AIAN communities (Boyd & Hunsaker, 2018).

The problem becomes even more magnified when addressing AIAN health equity. This is due to the strong distinction between the dominant mainstream culture and many AIAN cultures, where western 'evidence-based practices' are seen as culturally insensitive and intrusive (Whitbeck, Wells, & Welch, 2012). To counteract this issue, there has been intense focus in recent years on formal cultural tailoring, wherein interventions with demonstrated effectiveness in non-AIAN populations are methodically altered and tailored to the cultural realities of a specific tribe, ideally in direct collaboration with the tribe itself (Whitbeck, Wells, & Welch, 2012). Conversely, a growing approach in 'practice-based evidence' has been to develop programs specifically for AIAN communities from the ground up that can be shared and adapted across Indian Country (Chino & DeBruyn, 2006).

Finally, there is substantial need to support the development and mentoring of AIAN individuals as health equity researchers and practitioners. For example, the University of North Dakota Indians Into Psychology Doctoral Education (INPSYDE) Program has created a pipeline for AIAN students pursuing a degree in psychology. Increasing the diversity of the health equity workforce will only help to create more diverse and inclusive solutions for AIAN health.

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Division 45 Cultural Diversity and Ethnic Minority Psychology Journal Outgoing Editor

SU YEONG KIM, PHD

Division 45 Secretary Farzana Saleem Adjah conducted an interview with Su Yeong Kim

To give readers context, when did you start as the CDEMP editor and your term?
My term as CDEMP Editor started on January 1, 2019 and ends on December 31, 2024.

How has the mission and vision of the journal changed since you first started as editor?
The mission and vision of the journal has changed due to significant changes in the composition of editorial board members, also known as consulting editors. I have significantly expanded both the number of consulting editors and the field of psychology they represent. Traditionally, counseling psychologists were the mainstay of editorial board members and publications in CDEMP. I have expanded that focus to be more broad, with editorial board members and publications that encompasses developmental psychology to cognitive to health psychology. These changes have resulted in the impact factor increasing from 2.147 in 2019 to 3.30 in 2022.

What notable differences have you seen with the types of the articles that come into CDEMP overtime?
We are seeing more interest in discriminatory experiences than ever before. Different forms of discriminatory experiences, as it applies to populations not traditionally examined in the past, such as LGBTQ individuals with racial/ethnic minority identities. Discriminatory experiences are also being increasingly examined in national datasets, and experiences of discrimination across the globe are also being examined.

What is unique about CDEMP and why is a journal like this necessary and important for our field?
A specific focus on minoritized and marginalized groups in psychological sciences is important, given the increasing population size of such individuals in the U.S. Moreover, giving a voice to marginalized populations helps to decenter psychology's traditional focus on WEIRD (Western, Educated, Industrialized, Rich, and Democratic) populations.

How can journals do a better job at making the published papers accessible by the public/community?
All journals published by CDEMP come with a public significance statement to make the paper more accessible to the public/community. We can also include accompanying policy reports and video abstracts for the public/community to make the research more accessible.

What recommendations do you have for those who are interested in being a future journal editor?
Engaging with the editorial review process is key, starting with reviewing journal submissions, getting appointed as a consulting editor of a journal, and then Associate Editor to handle the manuscript review process of a manuscript, to become a future journal editor.

What new direction do you see the journal going/ what do you think is needed for the future mission and vision?
The journal should encourage more authors to do registered reports. This is a novel form of publications in the field, where the methods and proposed analyses are peer reviewed prior to the research being conducted, and can be provisionally accepted with the intention by the journal to publish the findings regardless of study findings. More registered reports can help us reduce the bias towards publishing papers with only significant research findings.

What types of changes do you think are necessary for all future journals?
Future journals should more seriously consider the diversity of the study samples they publish, and be explicit in having authors disclose the sample characteristics to better situate the research findings in the context of study participants' background characteristics.

What are your next steps after leaving this position? Do you have any plans to continue advancing the mission and vision of CDEMP / Div45?
I am planning to focus more on my research and advance the mission of CDEMP//Division 45 by continuing to examine factors that can dismantle the factors that disproportionately affect marginalized communities that lead to health disparities.

Division 45 Cultural Diversity and Ethnic Minority Psychology Journal Incoming Editor

ENRIQUE W. NEBLETT, JR., PHD

Dr. Neblett is the incoming Division 45 CDEMP editor and will begin his term on January 1, 2025. His responses to the interview questions are below:

How long have you been involved with the CDEMP journal and in what capacity?
I was first invited to serve as a consulting editor for CDEMP in 2009 and served in that role for 10 years until I became an associate editor in 2019. My first paper was published in CDEMP in 2013 (after numerous unsuccessful attempts)!

What is one thing you are looking forward to in your upcoming role as the CDEMP editor?
The one thing I am looking forward to most in my role as CDEMP editor is having the opportunity to shape the depth, breadth, and diversity of psychological science relevant to culture, ethnicity and race. My hope is that the work that we publish will have positive and lasting impacts on the psychological well-being of racial and ethnic groups who are underrepresented and experience marginalization.

What notable differences have you seen with the types of the articles that come into CDEMP?
For a long time, CDEMP has been, and continues to be, the leading forum for the psychological study of culture, ethnicity, and race. I would say that the most notable differences in recently submitted manuscripts are that we are receiving more papers that examine intersectionality and use diverse methods, particularly qualitative and mixed methods. The quality of quantitative and qualitative research published in the journal has also increased over time.

What is unique about CDEMP and why is a journal like this necessary and important for our field?
CDEMP is unique in its exclusive, unapologetic, and strengths-based focus on culture, ethnicity, and race for racial and ethnic groups that are underrepresented and experience marginalization. Although our goal should be for the psychological science of culture, ethnicity, and race to be valued and well integrated across all psychology outlets, we are not yet there as a field. A journal like CDEMP is necessary and important because authors don't have to justify a within group study. A journal like CDEMP is necessary and important, because our reviewers and editorial team understand and appreciate the context within which culture, ethnicity, and race operate, for both the research investigators who submit their work to the journal and for the groups that we want to better understand. A journal like CDEMP is especially needed in this time, when racial hate animus and anti-immigrant policy and sentiment are, again, on the rise. CDEMP can play a role in challenging and resisting systems that denigrate our psychological fortitude (R. Walker, 2020), wellness, and humanity.

How do you see CDEMP advancing racial equity and justice through the study of culture, ethnicity and race?
CDEMP first advances racial equity and justice by defining and describing the experiences of historically, racially, and ethnically subordinated and underrepresented people. Second, CDEMP advances racial equity and justice by sharpening our understanding of the psychological processes related to culture, ethnicity, and race that influence the experiences of underrepresented and minoritized racial and ethnic groups. This understanding lays the foundation to intervene, through programs, service delivery, and public policy to improve the well-being of racially and ethnically minoritized people and to promote equity.

How can journals do a better job at making the published papers accessible (and understood) by the public/community?
This is a challenge that the incoming editorial board will be considering as we review new submissions. Possible ideas include making more papers open access, even if for a short period (e.g., some journals make special issues open access for the first year). In terms of increased understanding, journals can encourage authors to use accessible language in scientific communication, and we can use community spotlights and social media to feature articles and structure exchanges between scholars and community practitioners about the research published in the journal and its potential implications for and impact on communities.

How would you like to see CDEMP evolve over the next 5 years?

By the end of my tenure as Editor, I would like to see more: 1) interdisciplinary scholarship; 2) diverse methods (particularly qualitative and mixed methods); and 3) scholarship that includes but moves beyond college students to center community voices and perspectives that extend beyond the United States (see Neblett, 2019, CDEMP). We will grow the number of studies, investigations, and reviews that move beyond solely documenting the harmful and deleterious effects of racism and other systems of oppression, to help us better understand how we can intervene, dismantle systems of oppression, and promote psychological well-being.

What recommendations do you have for those who are interested in being a future journal editor (of CDEMP or similar type of journal)?

I would recommend: 1) reading broad scholarship examining the psychology of culture, ethnicity, and race in not only psychology but also related fields; 2) publishing your own scholarship related to culture, ethnicity, and race, in diverse outlets; and 3) gaining diverse editorial experience (e.g., as consulting, associate, or guest editors). Our editorial leadership team hopes to discuss these recommendations and other topics related to publishing in CDEMP in a forthcoming webinar in 2025! Stay tuned!