CSAP
Cultural
Competence Series

Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice

7

Special Collaborative Edition

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Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice

Special Collaborative Monograph Produced in Conjunction With:
The Bureau of Primary Health Care,
Health Resources and Services Administration,
The Office of Minority Health, Department of Health and Human Services
The Center for Substance Abuse Prevention,
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Foreword

With "Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice," the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), joins with the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), and the Office of Minority Health (OMH) of the Department of Health and Human Services (DHHS) in producing the seventh volume of this unique series of cultural competence publications. This volume is the first of a series of "reoriented" cultural competency publications that expand the original substance abuse focus of this series to include broader health-services-oriented topics. The health services fields of minority health and primary health care now join this series in an unprecedented collaborative volume that views health care, prevention, intervention, and treatment as integral to the health status of ethnic, racial, and cultural populations. This volume explores questions of concern to health services, primary care, and substance abuse practitioners and evaluators wishing to enhance their abilities in working with the diversity of populations that embody the term "African American." This volume is intended for a broad audience of students, practitioners, clinicians, evaluators, and researchers wishing to broaden their expertise in the crucial issues that bridge culture and health within African-American populations. The topics contained in this volume are pivotal to the growing interest of the managed care industry in its attempts to foster positive health outcomes, increase quality of covered lives, improve accessibility to services, and increase consumer satisfaction.

This "Cultural Competence Series" has as its primary goal the scientific advancement of evaluation and practice methodology designed specifically for health services, primary health care, and substance abuse prevention approaches within the multicultural context of community settings. The various multicultural communities that make up the United States represent a rich and diverse ethnic heritage. The Cultural Competence Series is dedicated to exploring and understanding this heritage

and its critically important role in the development of culturally and linguistically accessible health services and substance abuse prevention programs.

The "Cultural Competence Series" provides the public health and substance abuse prevention fields a unique opportunity to formulate effective strategies that can be applied by professionals working in widely diverse settings. This unprecedented volume has established a framework for the transfer of innovative, cutting-edge technology in this area and a forum for the exchange of knowledge among program developers, implementors, and evaluators. It is the sincere hope of those who have contributed to this publication that it will stimulate new ideas and further prevention efforts among all Americans.

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Introduction: Diversity Among African Americans

Frances L. Brisbane, Ph.D.

Cultural pluralism, *cultural competence*, and *celebrating cultural diversity* are widely used terms that are narrowly practiced. Many educators, social scientists, and health professionals, as well as a segment of the media, have popularized these words to the height of a new fad. Businesses with products and services promote the celebration of cultural diversity as a strategy for multiplying their profits. At the same time, far too many not-for-profit agencies have done little more than adopted the words, transferred them into their annual reports, and continued to do business in a monocultural fashion. In "Developing Culturally Anchored Services: Confronting the Challenge of Intragroup Diversity" (chapter 1 of this volume), Judson L. Hixson quotes the late Whitney Young about the dangers of talking change rather than executing it: "The danger is that people may mistake what is basically a change in vocabulary for a change in behavior, practice, and attitudes." Hixson cautions not to be seduced by symbolic changes in today's climate, in which enticing rhetoric often takes the place of thoughtful analysis. Despite this unfortunate picture, three organizations have been beacons of light, illuminating for the nation a tradition in cultural competence: the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA), and the Office of Minority Health (OMH) of the Department of Health and Human Services (DHHS). The programs these

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agencies support demonstrate a belief that culture gives meaning, purpose, and focus to a person's life.

This monograph fits into the CSAP, BPHC, and OMH goal of enhancing the practice of culturally competent health services by helping to provide an understanding of the diversity among African Americans. It is hoped that this timely monograph will correct the notion that appearing to be and sounding culturally correct are sufficient; rather taking time to individualize services and respect the customs, beliefs, and practices of people from different cultures. The authors contributing to this monograph have devoted most of their careers to researching, lecturing, teaching, and writing about African Americans.

There is growing recognition that European Americans are not people of sameness. Their common race does not negate their multiple cultures. Likewise, African Americans have a legacy of cultural diversity. United States residents of African ancestry may claim cultures from the Caribbean, Bermuda, Canada, South America, and Africa (including those who immigrated after the enslavement period). These cultures are so unique that practices of some African Americans may not be understood by other African Americans. There is no one culture to which all African Americans or African Caribbeans belong. Diversity is expressed in each cultural group by where people of African ancestry grow up; by who raises them; by the extent to which their parents and grand ancestors conserve and perpetuate African values, rituals, and beliefs; by regional mores and customs; by gender socialization; and by age.

Hixson reminds us that diversity among African Americans is not new. Even slavery was experienced from different viewpoints. For example, field slaves had a totally different life from house slaves. Although African Americans, according to Hixson, shared a substantial common experience and feeling of being interconnected until the late 1950s or early 1960s, most African-American communities today show great diversity, which Hixson terms "second- and third-generation intracommunity cultural variations." He argues that these variations often vary so profoundly that they pose challenges for the development of culturally anchored intervention.

Many African-American values and rituals predate enslavement and are grounded in Western African cultures. Some are considered inborn African traits that were not lost through enslavement, segregation, and oppression, but instead through intergenerational influence grown in the hearts and souls of African Americans. These traits have traveled through time and are extensively replicated among African Americans today. Most conspicuous among these values and rituals are religion and spirituality. For most African Americans today, religion, often connected to churchgoing, and spirituality are major sources for preventing, healing, and treating problems large or small. Additionally, a high regard for social relatives is one of the values that approximate universality among African Americans. These social relatives, perhaps, have unknown blood ties through ancestral lineage, but their lineage is not authenticated nor is there a need to authenticate it. In their role as friends, they take the title of aunt, uncle, mother, sister, or brother, and their behavior is consistent with that of a blood relative. A social relative may be a godparent sanctioned at a religious ceremony, but more often the role of godparent is assumed through verbal agreement or an implicit social contract between parents and the person. It is not uncommon in African-American cultures for a friend to claim, without being asked, the godmother or godfather role. As a result, many African-American children have two or more godmothers and godfathers. Just like blood relatives, these social relatives are made part of the extended family and are expected to attend family gatherings and achievement ceremonies, such as family reunions and graduations.

Seldom are racism and oppression experienced by African Americans as a result of their cultural expressions; they are more likely the outcome of race and color discrimination. Consequently, race bonding usually transcends a group's cultural cohesion when survival and human rights issues are introduced. When maltreatment of African Americans by certain power entities is believed to be based on race, this belief can spiritually connect and unite African Americans and other people of African ancestry to respond across diversity distinctions from a context of race, recognizing that victimization based on race or color, when

unchallenged, can destroy the lifestyles (cultures) of a people and eventually their lives (race). The harsh realities and memories of enslavement tend to unify African ancestral people when a social injustice toward an individual has symbolic reflections of dehumanization.

Diversity among African Americans is most immediately recognized by language patterns that are common in different regions of the United States. For example, most southerners and northerners can be identified by the way each tells the same story. Many African Americans claim they can identify other African Americans' region of origin, regardless of how long they have lived outside of the region where they grew up, by listening to them speak. People from the Caribbean assert their propensity for identifying the island a person is from by the rhythmic flow of his or her speech. African Americans who were reared in Boston or Brooklyn tend to have two distinct speech patterns, and these patterns may differ from those of African Americans in the rest of Massachusetts or New York.

In "Contours of the African-American Culture" (chapter 2), Molefi Kete Asante, founder of the first doctoral program in African-American studies, examines historical events that gave rise to the many faces of diversity among African Americans. He addresses the migration patterns of African Americans within the United States and the impact their languages have had on American society. He reminds us that in the 17th century most Africans in the Americas did not speak English but spoke their native West African languages.

Belief systems, like geographical linguistics, are also diversified among African Americans. There are as many convictions about the way to get to heaven as there are religions. How religion is used as a therapeutic source for dealing with alcohol and drug abuse, terminal illnesses, or stress has distinctions related to gender, age, and geographical variations. Asante accurately reflects religion's maximum meaning to most African Americans when he says there is no separation between religion and life. People who do not have membership in a denominational religion attest to being as religious as those who attend church regularly, pay tithes, and consider themselves part of a church family.

Lacking any formal church affiliation, they may define "being religious" as having faith in a higher power on whom they depend as the first, last, or only source for help in coping with seemingly unmanageable problems or debilitating diseases. Others may equate being religious with "being a spiritual person"—they view religion and spirituality as so closely intertwined that the two concepts blend as one. Praying among older African Americans is a daily ritual, while many younger people ridicule "being on your knees" as the reason that African Americans do not get ahead. A significant number of African-American youth do subscribe to the usefulness of prayer, religion, and church attendance. They are the next generation's church leaders. They sing in the choir, are junior ushers, and youth church ambassadors. But there remains a critical mass who are impatient and have found alternative ways, some illegal, to receive gratification. The consequences of these alternatives are sometimes incarceration and a ruined future.

A large number of young African-American men and women are Muslims and role models of high moral values. They are concerned about children and the elderly, and are viewed as making a difference in the African-American communities where they live. Because of many significant religious influences in African-American communities, the term "the Black Church" no longer has the same meaning it had 75 or more years ago.

Lawrence E. Gary and Melissa B. Littlefield argue in "The Protective Factor Model: Strengths-Oriented Prevention for African-American Families" (chapter 4), that religion and spirituality have empowered African Americans in every area of their lives. In all urban communities characterized as African American, one is likely to find faith or church communities of Seventh-Day Adventists, Jehovah's Witnesses, and traditional African religions, many with origins in one or more African countries.

The authors of this monograph argue that the need for cultural competence in providing health services also extends to age and gender groups. According to Marion E. Primas and Sharon E. Barrett in "African-American Women: A Health Crisis Perspective" (chapter 3), African-American women suffer disproportion-

ately in a number of areas including heart disease, breast and lung cancer, diabetes, cerebrovascular disease, hypertension, weight disorders, homicide, and unintentional injuries and substance-abuse-related illnesses. Primas and Barrett discuss these conditions in a perspective of determinants of healthy behavior, including lifestyle, environment, and access to health care. They conclude that the provision of culturally and linguistically appropriate health services hold the potential for improving the health status of African-American women and all people of color.

Young African Americans, like their older parents and relatives, are not one-dimensional. Media spotlights on isolated issues such as teenage pregnancy, gangs, substance abuse, and schools in turmoil do not describe the experience of most African-American youth. In fact, there is much evidence, according to the authors who contributed to this monograph, that most children from communities plagued with problems are tenacious in their resolve to "be somebody." Their parents, regardless of the lack of external resources available to them, usually provide strong family values as well as lessons in how to turn adversity into advantage. Unfortunately, adversity does abound in many African-American communities, leaving even strong-willed parents and their children feeling afraid of the future. Traditional pathways from high school to college into a career pattern of upward mobility are becoming less certain as well as too costly in the face of diminishing grants and loans. With advanced technology making yesterday's jobs obsolete and tomorrow's job market uncertain, there is a relatively universal fear of the future. Anything that is hard to predict is even harder to plan for. Just as this uncertainty has created problems for most young people in America, it has had a negative effect on the ability of many African-American youth to plan for the future. Yet in spite of this dismal picture, many parents work two jobs, accept menial labor, and make major self-sacrifices to educate their children. They continue to believe education is the route out of poverty and hopelessness.

There are many African-American families who have middle to upper incomes. They often consist of two professional parents in high-status occupations—proof that the "Cosby Show" is a re-

alistic portrayal of a segment of the African-American population. These families are part of the diversity in geographically defined African-American neighborhoods and in other racially and culturally diversified communities.

Lawrence Gary's chapter includes a discussion of his research on the attributes of well-functioning African-American families. He also introduces the body of literature by well-known social scientists, including Andrew Billingsley and Robert Hill, that compellingly renders Patrick Moynihan's 1965 depiction of African Americans as myth. As a group, African-American families are not now—nor were they then—as dysfunctional as Moynihan described. Gary states that when socioeconomic factors are controlled, African-American families function quite well by most standards. The aspirations, dreams, and determination of most African Americans are not limited by "inadequate income." The old adage, "making a way out of no way," was echoed in youth by many of today's over-50 generation of African Americans. It is significant now for their children and grandchildren.

This monograph presents a common theme of strength, empowerment, and resiliency in its profile of African-American families. There were few similar characterizations of African Americans in the literature before the 1960s when most authors wrote only about the problems of Black people. Approximately 30 years ago, African-American researchers began to identify the positive characteristics of African-American families. They changed the lens for viewing this population. Cheryl Davenport Dozier and Geraldine Jackson White, in "The More Things Change, the More They Stay the Same: A Framework for Effective Practice With African Americans" (chapter 5), declare that substance abuse treatment, like other forms of treatment, should begin by acknowledging the client's strengths. They outline how to effectively incorporate the strength perspective into a model for working with African Americans. Their suggestions are likely to produce universally positive results among the diverse cultural groups descended from Africans.

"Culturally Based Health Promotion: Practices and Systems" by Ronald L. Braithwaite and "Race, Health Status, and Managed Health Care," by King Davis are the concluding chapters of this

monograph. They give special insight into the place of culture in providing competent services to African Americans. Braithwaite outlines barriers that may prevent African Americans from inclusion in programs for health promotion. He and Davis alike list lack of access to health services, often attributed to unemployment or employment without insurance coverage, as problems for many African Americans.

Davis advocates integrating cultural competency in treatment and prevention, and reducing the cost of health services for African Americans. At a time of prepaid and predetermined costs for medical procedures, many African Americans enter the health care system with chronic illnesses. Davis' chapter indicates that attention to the cultures among African Americans will help managed care to work effectively for them. Davis draws our attention back to the enslavement period when, ironically, African Americans' health was a high priority because of the relationship between good health and high work production. He mentions that at the conclusion of African-American enslavement, other means of providing health care for a relatively impoverished people had to be established. African Americans today who are not valued as human capital in their jobs, who are not greatly needed for business success, and who are easily replaceable are likely to be poorly insured or uninsured. CSAP, BPHC, and OMH are to be commended for their trailblazing role in making information in these monographs available. Those who want to practice cultural diversity have a blueprint for doing so. Those who believe problems can best be prevented when they know how to incorporate cultural specifics into the prevention matrix for African Americans of diverse cultures now have guidelines. And according to Gary, focusing on prevention is pro-family and is a cost-effective approach to eliminating the host of preventable conditions that adversely affect the health status of African Americans.

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Developing Culturally Anchored Services: Confronting the Challenge of Intragroup Diversity

Judson L. Hixson

Introduction

As we approach the end of the 20th century, the tremendous social problems affecting our Nation's children, families, and communities have remained, at best, unresolved; in many places, these problems are either on a growth trajectory or have already reached crisis proportions. Throughout America—from rural towns to major urban centers—communities are struggling with the impact of poverty; alcohol and drug abuse; violence; and socially and personally destructive behaviors, conditions, and circumstances.

Yet nowhere are the consequences of these social cancers more apparent than in African-American communities and other communities of color. These communities continue to be disproportionately impacted by economic desertion, political isolation, manipulated or manufactured dependency, and the resulting deterioration of family and other important community services and structures—especially schools, churches, and human or social service institutions. Perhaps what has been most destructive

and frightening is a growing loss of faith by many of our youth in the ability of the community's adults and institutions to protect and nurture them or to provide them with a positive vision and purposeful pathway to the future.

Some believe not only that these problems cannot be solved through government programs or institutions, but that preventing them should not even be a priority governmental concern, since they result simply from individual or group pathologies, deficiencies, or choices (e.g., D'Souza, 1995; Brimelow, 1995; Herrnstein & Murray, 1994). Rather than prevention, treatment, or other support systems, their responses focus on calls for personal responsibility, harsher laws, and more prisons.

Yet for a growing number of people in African-American and other communities across the country, there is an increasing (though certainly not universal) convergence of opinion that these challenges have resulted from a complex interaction of individual, social, economic, and other societal factors and policies, not simply personal choices or inadequacies. In fact, the continuing spread of these problems across lines of geography, class, color, or community provides clear evidence that the issues go far beyond individual or community pathologies, values, choices, or inadequacies. Our apparent inability to make significant progress in solving or preventing these problems, then, is not the result of inherent deficiencies in the people, but in an inaccurate framing of the problems. As a result, there has been an inadequate response to the problems—in society as a whole; in local communities; and in the arenas of prevention, treatment, social work, education, and other health and human services.

In particular, the pattern of piecemeal responses to individual problems has resulted in an overly fragmented, specialized, and standardized assortment of services, programs, and policies—including prevention, intervention, and treatment protocols. Even more problematic, this fragmentation of effort, resources, turf, accountability, and research has hindered our ability to recognize broad and deeply embedded patterns of systemic dysfunction in our institutions, communities, and society as a whole. This dilemma has been particularly evident in our attempts to address the issues of substance abuse and of other health-related, socially

destructive behaviors affecting African Americans. Clearly, new responses are needed.

This chapter suggests that the basic principles of a culturally anchored, development-focused, systemic approach to prevention, intervention, and treatment provide the most promising foundations for such new responses. These principles can provide the framework for a comprehensive, integrated health and human services system than can both reverse patterns of personally and socially destructive behavior and, perhaps even more important, provide a catalyst for developing the tremendous reservoir of human and social capital in the African-American community.

The importance of culture as a foundation for effective health and human services, however, is not a new idea (Devore & Schlesinger, 1981, cited in Gordon, 1993), particularly in terms of services for African Americans and their communities (e.g., Allen, 1978; Bass, 1982; Nobles, 1980, 1986; Oliver, 1989; Brisbane & Womble, 1992; New York State Office of Alcoholism and Substance Abuse Services, 1993). Similarly, other researchers and practitioners have developed a myriad of strategies, approaches, and paradigms for incorporating issues of cultural diversity and competency into prevention, treatment, and other health care and human services programs generally (e.g., McAdoo, 1993a & b; Kavanaugh & Kennedy, 1992; Matiella, 1994; Lynch & Hanson, 1995; Finn, 1994; Arredondo, 1992; Office for Substance Abuse Prevention, 1990; Orlandi, 1992). Collectively, this body of work from both research and practice has provided important insights, principles, and specific strategies for developing culturally appropriate or competent services for African-American and other nonmainstream cultural groups. Clearly, a strong foundation has been built.

However, given the increasingly complex, systemic, and paradoxical nature of the new and evolving dimensions of diversity within the African-American community, coupled with rapidly and dramatically changing social, political, and economic contexts, the need for further exploration of a more systemic set of principles to guide the continuing development of culturally anchored service systems is increasingly necessary. In particular, the challenges are (1) to explore new possibilities for services that are

deeply embedded in, build on, and leverage traditional cultural foundations and community strengths and resources, or (2) where necessary, reactivate or reconstruct these services while framing a proactive advocacy agenda for changing policies and perspectives regarding both the purpose and process of health and human services generally, and specifically those related to prevention and treatment.

The move toward culturally anchored strategies, however, will require more than simply new information, strategies, or organizational structures. Though all are necessary, by themselves these things are insufficient. Three actions are required to achieve the degree of necessary change: First, we must more systematically explore the contextual factors and forces that impact the culture, circumstances, and what Roger Barker has called the "psychological ecology" (cited in Gallagher, 1993) in today's African-American communities. Second, we must openly and honestly confront the "paradigm paralysis" that has locked too many of our health and human service systems and institutions into ineffective or even counterproductive priorities, structures, and patterns of action. And finally, a conceptual cleansing of old ideas and demonstrably erroneous or inappropriate knowledge and strategies is also necessary.

In each action, however, we must avoid symbolic changes, particularly in the current environment where enticing rhetoric often takes the place of thoughtful analysis, and the search for magic solutions frequently supersedes the need for carefully constructed strategies for meaningful change. Effective development and implementation of culturally anchored systems for primary health care, prevention, and treatment can never be accomplished if we simply overlay some culturally specific or culturally appropriate strategies or terminology on a culturally inappropriate or even culturally hostile approach to clinical and social services, organizational design, or criteria for success. Whitney Young once put it this way: "The danger is that people may mistake what is basically a change in vocabulary for a change in behavior, practices, and attitudes. While practically all Americans have learned to talk inoffensively, not enough have learned to think differently or to act positively."

Our challenge, therefore, is to find ways to move beyond simply improving the systems we currently have, or developing small-scale, isolated alternatives or aberrations, to rethinking and reconstructing the basic principles and assumptions that underlie them. As futurist Alvin Toffler has noted: "The illiterate of the 21st century will not simply be one who cannot read or write, but one who cannot learn, *un*learn, and *re*learn."

In framing the discussion within this chapter, care has been taken to avoid suggesting that any single model or approach would be appropriate or effective for all African-American people in all places under all circumstances. The truth is that despite the growing evidence of the effectiveness and efficacy of culturally anchored approaches, there is much yet to be learned. In this vein, the insights of an axiom called "Grossman's Law" are relevant: "Complex problems have simple, easy-to-understand, *wrong* answers." Given this caveat, let's begin our journey.

Culture and Beyond: The Challenge of Intracommunity Diversity

Typically, discussions about cultural diversity tend to focus on the pattern of beliefs, dispositions, and behaviors that are traditionally or otherwise generally considered characteristic of an identifiable national, ethnic, or racial group. One widely used description defines culture as "the shared values, social norms, mores, traditions, customs, arts, history, folklore, sanctions, and institutions of a people" (Orlandi, 1992). On one hand, this level of generalization helps us identify and, hopefully, understand important differences in how various groups have historically or traditionally organized themselves to address basic human needs and challenges (see also Trompenaars, 1994).

On the other hand, such broad generalizations can mask important contemporary intragroup and intracommunity variations, especially among groups whose trajectory of cultural evolution has been deliberately and systematically altered, interrupted, or distorted through their encounters with other cultural groups or institutions. Such is clearly the case for African Americans (e.g.,

Jackson, 1992; Lee, 1992; Kozol, 1991, 1995; Brisbane & Womble, 1992; Kunjufu, 1993).

Accordingly, for the purposes of this discussion and based in part on the work of Axelson (1985, cited in Gordon, 1993), I have expanded and reframed Orlandi's definition of culture in terms of three cultural structures. From this perspective, culture is the shared beliefs, values, social norms, traditions, folklore, knowledge systems, forms of expression (arts, language, clothing, ceremonies, etc.), and history of a group that

- provide the framework within which we define ourselves individually or as members of one or more groups, including personal and social roles, relationships, and structures we adopt or create;
- serve as the lens or filter through which we interpret and make sense of the world, including how we see our place in it; and
- guide how we interact with, respond to, influence, and are influenced by people, events, circumstances and conditions (real or perceived) in our environment (Hixson, 1994).

Clearly, this depiction does not cover all possible cultural characteristics that distinguish one group from another (see figure 1). It does, however, provide a synthesis of important cultural structures that allow us—at least somewhat systematically—to categorize (1) the behavioral patterns or tendencies within groups, and (2) the points at which cultural distortion or disconnection typically occur, and around which cultural reclamation, reconnections, or reconstruction can be focused.

The following are some of the more explicit elements of a culture that have a direct impact on people's beliefs, values, attitudes, perspectives, and behaviors:

- Identity development (multiple identities and contextualized concepts of self-worth).
- Rites of passage (characteristics of adulthood and maturity), role of sex and sexuality.
- Images, symbols, and myths.
- Role of religion and spirituality.
- View, use, and sources of power and authority.
- Art forms (visual, musical, literary).
- Role and use of language (direct or implied).
- Ceremonies, celebrations, traditions.
- Learning modalities, acquisition of knowledge and skills.
- Patterns of interpersonal interaction (idiosyncratic behaviors, "in the family" meanings).
- Assumptions, prejudices, stereotypes, and expectations of others.
- Reward/status systems—meaning of success, role models/heroes.
- Concepts of sanction and punishment.
- Social groupings—support networks, external relationships, organizational structures.
- Perspective on the role and status of children and families.
- Patterns and perspectives on gender roles and relationships.
- Means of establishing trust, credibility, and legitimacy (appropriate protocols).
- Coping behaviors and strategies for mediating conflict or solving problems.
- Sources for acquiring and validating information, attitudes, and beliefs.
- View of the past and future, and the group or individual sense of place in society and the world.

Figure 1.   Elements of the cultural mosaic

Diverging Pathways of Personal and Social Development

Diversity within the African-American community is not a new phenomenon. Whether it was, for example, free Blacks versus slaves, field slaves versus house slaves, the educated versus the uneducated, or urban versus rural, the African-American experience in America has never been monolithic. However, until the late 1950s or early 1960s, there was a substantively greater sense of commonality and

connectedness within African-American communities than is typi-
cally the case today. Consider the following:

> *We are one, our cause is one, and we must help each other; if
> we are to succeed (Frederick Douglass,* North Star *editorial, 1847).*

> *The dawn of a new day is upon us and we see things differently.
> We see now not as individuals, but as a collective whole, having
> one common interest (Marcus Garvey,* Philosophy and Opinions
> of Marcus Garvey, *1923).*

> *We've got to change our minds about each other. We have to
> see each other with new eyes. We have to see each other as
> brothers and sisters. We have to come together with warmth so
> we can develop unity and harmony (Malcolm X, "The Ballot or
> the Bullet" speech, April 3, 1964).*

The erosion of this general sense of commonality began to
accelerate systematically and systemically largely as a result of
the impact (if not always the intent) of major social and political
shifts in American society. In particular, these societal shifts in-
cluded (1) the evolving civil rights movement and its impact on
our schools (including the push or pull toward desegregation or
integration and the Black Power era); (2) simultaneously increas-
ing and decreasing opportunities for economic advancement;
(3) the "Great Society" initiatives; (4) the general switch from overt
to covert racism; and (5) the growing power and pervasiveness of
mass media.

I do not suggest that these are the only issues that impacted
African-American communities—clearly, they are not. Nor is my
purpose to revisit the ongoing debate about the efficacy or the "at
what costs" question of the first three of these shifts. Instead, the
purpose is to note that in each case these social phenomena have
had an enormous systemic and continuing impact with both posi-
tive and negative consequences for the African-American com-
munity, and that the balance over time has shifted in a decidedly
negative direction. The intensity of the impact has been further
magnified by the fact that for more than 40 years, these phenom-
ena have been institutionalized in government policies and struc-

tures, including, most prominently, those underlying health and human service systems. Such institutionalization is a prime example of unanticipated consequences of purposeful action.

Because of the erosion of commonality among African Americans accelerated by these socioeconomic changes, many if not most African-American communities now face patterns of second- and third-generational variations in intracommunity culture. These variations are often as significant as those between African Americans and the majority society and, in some cases, are even more profound and disturbing. This evolving pattern of intracommunity diversity poses important challenges for the development of culturally anchored interventions because, in many cases, the expressed (as opposed to traditional) culture of segments of the community reflects serious distortions, or even abandonment, of core values and traditions of African-American heritage. This circumstance suggests that we can no longer reliably assume that the traditional cultural frameworks—identity, values, beliefs, relationship patterns, family structures, and so forth—are the primary guiding forces in the lives of all of the community's residents, or in some cases, significant segments of the community as a whole.

Yet this reality does not mean that these individuals, subgroups, or communities have entirely lost their connectedness to African-American cultural traditions. In fact, in many communities we are witnessing a resurgence of African traditions and values. From Afrocentric schools to revitalized roles for churches to reassertion of the importance of the African part of our African-American identity, the return to our roots is evidence of the inherent resilience of African-American culture and people. But in many other communities, those traditions have been displaced, weakened, or distorted as a result of the evolving and expanding impact of the social, economic, and political shifts outlined above. The patterns of impact, however, are not linear cause-effect or stimulus-response processes, but more complex, and sometimes insidious, organic ones that can best be understood through what I have termed "contextual overlays" (Hixson, 1993).

The concept of contextual overlays provides a means for systematically thinking about the ways in which traditional group or community norms, values, and mores are altered as a result of the influence of conditions and circumstances of the contexts (physical, social, economic, political, institutional, etc.) within which they exist. These influences can cover a full spectrum ranging from empowering and validating to debilitating and destructive. As an analogy, consider how a teak overlay on particleboard adds beauty and value to what is essentially compressed sawdust, while an overlay of paint on mahogany masks the natural beauty and diminishes the value of the original wood.

For oppressed or marginalized groups, the impact tends to be skewed disproportionately toward the negative, and the differential impact within the group is typically greater. The direction, intensity, and differentiation of impact is also a function of the
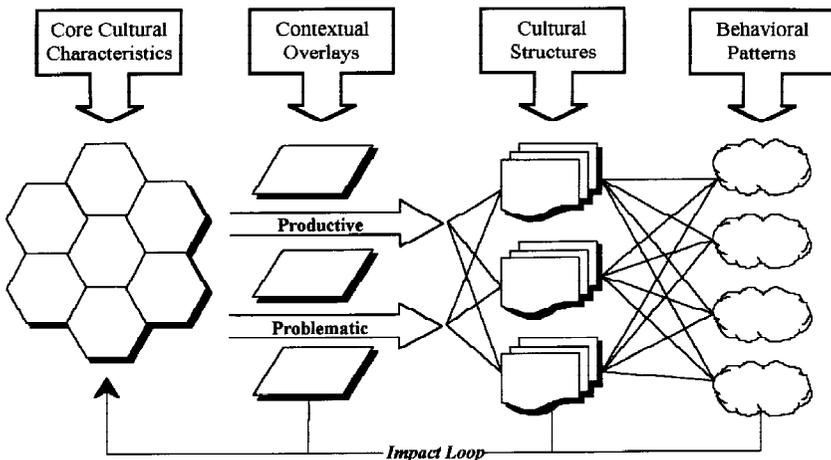
Figure 2.   The top part of this graphic depicts the journey from cultural traditions to individual behavior. As described in the text, cultural traditions and practices are filtered through three core contextual overlays. The impact—which can be productive or problematic—impacts on how these traditions are translated into the three cultural structures. The interaction among the elements of these cultural structures produces the array of behaviors that may reflect, or may be (or appear to be) fully disconnected from the original traditions. In each case, the impact of the contextual overlays or changes in cultural structures and behavioral patterns impact on the core cultural characteristics, and the cycle repeats.

nature and intensity of the relationships and conflicts between mainstream and nonmainstream groups, particularly when racial differences are involved—although other ethnic or religious differences are often equally powerful, as conflicts in Bosnia or Northern Ireland clearly demonstrate. Figure 2 provides a graphic representation of this contextual overlay process.

There are numerous individual overlays, but three categories tend to be most common, most powerful, and most problematic with regard to the incidence and impact of drug involvement and other socially destructive patterns of behavior among African-American individuals and communities. The first overlay reflects the growing diversity of the shared patterns of experience among African Americans, individually and as a community, in five interrelated areas: socioeconomics, community environment and institutions, family structures and circumstances, peer group(s), and relationship to the dominant culture. In each

Levels of Impact

Reinforced   Displaced   Distorted
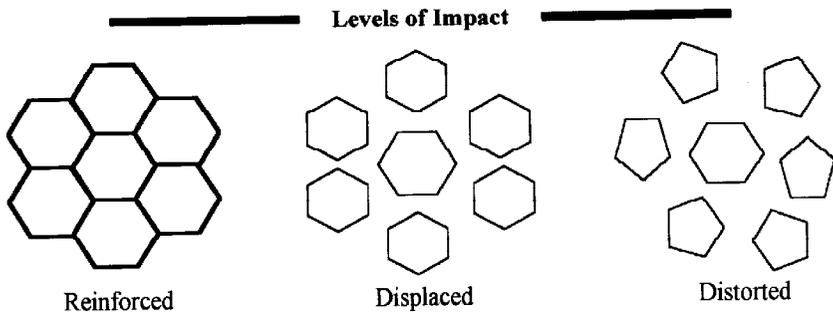
In general, the effect of this impact loop includes situations where the core characteristics are strengthened and reinforced; where they are displaced and become disconnected from each other; or where they are thoroughly distorted. In the case of displacement, an example would be where the traditional sense of collective responsibility for the community becomes focused on only one group within the community, ignoring the impact of the group's behavior on the community as a whole. An example of distortion would be where communitywide concern for all children becomes a belief that it is only the parents who are responsible for ensuring that children are raised properly. In more extreme cases, cultural traditions and values can be "destroyed" and may need to be rebuilt; e.g., where becoming acceptable to the mainstream group becomes so important that individuals adopt behaviors deliberately designed to disconnect themselves from identification with their cultural, ethnic, or religious group or heritage.

of these areas, the African-American experience in the United States has become increasingly fragmented and differentiated among segments of the overall community. As the shared patterns of experience of various subgroups (e.g., those with more or less education or economic resources) became less common, these segments of the community began to develop along parallel and, in some cases, diverging trajectories.

Many who were economically successful moved from the community; families that were once supported by the community were increasingly left to fend for themselves; in schools, students were increasingly tracked and isolated from each other; and in the community, those patterns were often repeated and reinforced. Formerly strong and positive cultural bonds and traditions weakened, and the way in which many cultural patterns were played out in people's day-to-day lives changed. The commonality of racism notwithstanding, the lenses through which we saw the world and our place in it and the ways in which we viewed each other were becoming different (Jackson, 1992; Perkins, 1985; West, 1993). That process continues today.

The second set of overlays reflects the conditions made available to or imposed on specific groups, which affect the groups' access to people, places, institutions, and opportunities in mainstream society, as well as within their own cultural group and community. As educational and economic levels and access to mainstream society increased for some African Americans, so too did the degree of socioeconomic class distinctions, estrangement, and conflicts. Indeed, many fell victim to the myth that you can judge the progress of a people by the illusion of equality of some of its members. To be sure, there was progress toward a relatively more equitable, if not equal, society; and for many, significant gains were made. However, to presume that this apparent rising tide of opportunity raised all or even a majority of African-American ships is, at best, an exercise in delusion. Even for those ships that were raised, the question of "at what costs" remains an important individual, cultural, social, and political one.

Again, this differentiation impacted each of the cultural structures outlined at the beginning of this section. But perhaps the most significant change was in the way we began to define our-

selves. Those who had become more successful in negotiating the mainstream society also began to adopt a decidedly nontraditional belief in individualism, with the corollary that success or failure is primarily within the province of individual ability, character, and will (e.g., Steele, 1990). Many forgot the foundations on which their own success had been built—ladders and stepping stones provided by others who would not be able to take advantage of them for themselves. Many also began to adopt a posture of "otherness" within our communities—the collective "we" was increasingly punctuated by "us" and "them." As a result, a diminishing sense of collective commitment to one another and to the community as a whole began to emerge. In particular, the expectation emerged that those who experienced some measure of success also had the responsibility to both give back and to reach back and bring someone else along; that is, to construct an expanded agenda of possibilities for productive patterns of experience and more accessible pathways of access to people, places, institutions, and opportunities for the next generation.

Even more problematic is that this process of increasing differentiation in shared patterns of experience and access tends to become a self-reinforcing and replicating cycle. This cycle increases in intensity the younger the age at which its effects become evident. One need only consider the decreasing age of youths participating in negative activities (such as gangs, violence, and drug abuse), or the ages at which they become disconnected from schools, and consider how we have responded to them, e.g., the decreasing age at which we are willing to send young people to adult prisons.

The third contextual overlay is the process of cultural assaults, which disable or corrupt basic cultural norms and support systems, individual and group perceptions of self, and especially beliefs about possibilities for the future. These cultural assaults reflect both the unrealized expectations and failed promises of desegregation/integration, expanding economic opportunities, and the Great Society programs. These assaults are coupled with the influence of the other two social shifts outlined earlier: the shift from overt to covert racism and the growing power and pervasiveness of the mass media.

In the case of desegregation/integration and expanding economic opportunities, general and genuine equity of access to people, places, and resources, and equal treatment by the mainstream society have never materialized for African Americans. Instead, the process has had the impact of draining important individual, social, economic, and spiritual resources from many African-American communities, schools, and churches, leaving them not only racially segregated, but more isolated economically, socially, culturally, and politically than ever before (Tidwell, 1994).

Even more destructive was the not-so-subtle undertone in much of the integration rhetoric and policies that the inferior circumstances of African-American communities, and especially their schools, was not the result of systematically and deliberately inequitable treatment, but of inherent deficiencies in the people themselves. Good neighborhoods and schools, for example, became synonymous with those that were predominantly White. For many in the African-American community, the result of the Supreme Court's 1954 Brown decision to reverse the negative impact of segregation on "the hearts and minds" of African-American youth actually was to reinforce their feelings of inferiority and estrangement from the larger society.

Similarly, the promise of the Great Society's War on Poverty programs degenerated over time into what some have termed a war on poor people—the major beneficiaries being those who worked in or provided services to the programs, rather than those for whom the programs were designed. This is not to say that current proposals for changing the services are likely to be any more productive or that they may in fact do even more harm. However, the view that "the system is broken" is largely accurate.

The impact of the shift from overt to covert racism, and the shift back to more overt forms, has developed into a far more complex and insidious phenomenon than the explicit segregationist policies of earlier times. Bolstered by relentlessly negative portrayals of African Americans (especially males) in the mass media (Kunjufu, 1993), there has been a resurgence of ideology masquerading as social science research, and a clamor for "color-blind" equity framed by charges of reverse discrimination and denun-

ciations of affirmative action and multiculturalism. This new pattern of racism has motivated both unity and divisions within the African-American community. In particular, those who believed that their level of education or professional success would inoculate them against the subtle indignities and overt discrimination of racism have been sorely disappointed (Cose, 1993; West, 1993; Eddings, 1995).

Further, as America's economic growth began to diminish and social problems (especially drug involvement, gang activity, and violence) spread, the society looked for someone to blame. As U.S. Representative John Conyers observed in 1978, "A competitive society needs an underclass—a class of the unemployed who functions as the targets for the displacement of the frustrations, anxieties, and fears by those others who are employed." The result has been a pattern of "victimization" of poor African Americans and other people of color, particularly African-American, Latino, and American-Indian males, and urban welfare mothers. While not particularly subscribing to the mass conspiracy theory, this writer need only refer one to the papers or news programs to recognize the consistent image of African-American communities largely as repositories of dysfunctional, immoral, violent, lazy, or otherwise generally undesirable people who are undeserving of either compassion or help—much less long-term support.

One of the most pernicious examples of these collective attitudes is society's response to children who have been affected by trauma or tragedy. For example, in a recent tragic event in suburban Chicago in which seven young people were killed when a train hit a school bus, churches opened their doors day and night; calls offering support, help, and condolence poured in from across the country; and a flood of counselors were dispatched to the homes and schools to help the other students and families cope with the trauma. This was indeed an appropriate and inspiring response.

However, for inner-city children who witness death and experience trauma on a regular basis, there is rarely, if ever, any such outpouring of compassion or support. The message that they and their communities are not valued by the larger adult society is powerful and has shaped their view of who they are, where

they fit (or do not fit), and what their options for the future might be.

Other cultural assaults have had negative impacts on various communities, but have had a disproportionately negative impact on the African-American community. The focus on materialism and power has been particularly damaging. The underlying message of that focus is that who you are is determined by what and how much you own, where you live, or the degree of power you have over other people. While these messages and values have clearly affected American society as a whole, for those who see little external validation of their inherent worth and value, the drive to obtain at least the symbols of personal status and power can often override almost all other influences.

The values of materialism and power also underlie parents working second jobs to buy things for their children while depriving them of the more important gifts of time and attention; someone selling drugs to purchase status symbolized by $150 gym shoes or luxury cars (or more recently, sport utility vehicles); gangs marking and defending territory as a source of what they believe is an otherwise unavailable sense of power and control; or even companies that are willing to trade the welfare of their employees and communities in a relentless pursuit of higher profits. The results have become increasingly destructive. An interesting and controversial discussion of this broader phenomenon is contained in the book "Warning: Nonsense Is Destroying America" (Ruggerio, 1994).

Only a few examples of how contextual overlays have impacted African Americans and their communities have been included in this discussion. However, they represent a cross section of the processes and circumstances through which displacement and distortion of cultural values and traditions can lead to parallel or diverging pathways of individual, cultural, and community evolution and development. In general, the current impact of these processes, namely, on drug involvement and related issues, can be summarized by four interrelated and mutually reinforcing dimensions of increased vulnerability of African-American communities.

First, there has been a general weakening of the cultural bonds and values—the sense of "the village" that historically held African-American communities together. This village, in spite of all threats and obstacles, allowed us to celebrate individual successes and victories as our own. It also helped us remember our responsibility to the community and each other, particularly our sense of collective responsibility to the children, regardless of our individual status.

Second, there is increasingly a sense of identity based on class or status that, in many places, has resulted in an almost castelike structure of divisions within and among African-American communities and people. Cecilia Firethunder (personal communication, 1993), in reflecting on conditions in Native-American communities, has termed this phenomenon "lateral oppression." This division has reduced or inhibited our ability to recognize continuing commonalities of interests, issues, and culture that supersede number of degrees, economic or social status, or place of residence. As Ralph Ellison reproved in 1986, "We change our environment, our speech, our style of living, our dress, and often our values … we become somebody else" (Ellison, 1986).

Third, a sense of hopelessness and powerlessness is growing among those who have not been helped or encouraged to achieve any meaningful degree of entry, much less success, in mainstream society or community institutions. Many have also abandoned belief in the customary pathways (e.g., education) as viable, or even desirable, goals or priorities for their lives; over time, they have become indifferent, disconnected, and even hostile to the people and institutions that have traditionally been a source of our collective strength, especially schools, employers, and the church (e.g., Padilla, 1993). Some students who do well in school are ridiculed as "acting White"; people who seek employment may be denigrated for having sold out to work for "the Man"; and those who promote and live by our traditional mores and values are often viewed as uppity, arrogant, and other more derogatory terms. Even more problematic is that what may have initially been a largely temporal, isolated pattern is becoming a cross-generational cycle, fueled and reinforced by the experience of systematic rejection by, and exclusion from, the very institu-

tions to which people most need to be connected and nurtured. Feelings of hopelessness and powerlessness often precipitate a fatalistic disposition toward point-in-time reaction to the immediate conditions and circumstances with which one is confronted, and toward having little if any regard for long-term consequences or the possibility of changing them. It is not simply that people don't understand the consequences of their actions, though this may sometimes be true. Rather, they have lost the capacity to care about them.

Finally, there is a pervasive and entrenched sense of isolation and abandonment. This sense of being isolated from the larger community and society affects both the peer groups within which we operate, as well as those to which we turn for support and guidance. In African-American as well as other communities, we have allowed too many youths, adults, seniors, and families to find themselves connected by default to negative peer groups and disconnected from more positive support systems. The repercussions have been detrimental to their well-being and to the community as a whole.

Again, the point of this discussion is not to suggest that African-American communities as a whole are, or are becoming, dysfunctional or pathological, or that they are disintegrating. Nor is it to suggest that these types of cultural distortions occur only in the African-American community. In fact, in many majority communities, adults and especially young people are having similar and often greater problems with detrimental social values, structures, and relationships (Garabino, 1995; McKnight, 1995; Lipsitz, 1995; the Anne E. Casey Foundation, 1995).

Instead, the purpose has been twofold: first, to suggest a framework for understanding the processes by which sustaining cultural traditions and structures can be displaced or distorted; second, to explore briefly how these cultural disruptions have both created new patterns of diversity within African-American communities and increased the vulnerability of individuals and communities to problems of alcohol and drug use, violence, weakened families, and so forth.

The lessons to be learned go beyond the individual examples presented here to the systemic patterns of impact they reflect and,

paradoxically, the possibilities they represent—both for understanding the evolving dimensions and patterns of diversity within the African-American community, and for identifying critical points of intervention around which paradigms for culturally anchored services can be organized. Some initial ideas for beginning that process is the focus of the next section.

Foundations for Culturally Anchored Health Services

The preceding section outlined some of the systemic factors that have negatively impacted the cultural fabric of many African-American communities and increased both individual and community vulnerability to a variety of personally and socially destructive behavior. While none of this information is necessarily new, it is not typically discussed in terms of its impact on the systemic cultural structures that are the critical foundations for healthy communities that nurture and sustain healthy people. Similarly, the general debate over health and human services, especially in terms of prevention and treatment, rarely recognizes the need for viewing such services as part of the social ecology of the community—therefore requiring these services to be anchored in and to provide anchors for these basic cultural structures.

The challenge, then, has been and remains to confront on a professional and personal level some of the underlying assumptions of the current health/human service and prevention/treatment paradigms. The following suggests a series of focal points for beginning such a dialog or *Indaba.* According to Lovelace (1994), "Indaba is a Zulu word meaning intense discussion. In ancient times and in many governing bodies today, the ruling king will call an Indaba to receive valued counsel from key individuals held in high regard. The Indaba emphasizes lengthy, spirited discourse through a debate process stressing the power of reasoning." In this spirit, it is hoped that these propositions and principles can provide a beginning framework for the design of new paradigms and foundations for health and human services generally, and particularly for prevention and treatment in the African-American community.

Rethink the Paradigm for Culturally Anchored Health and Human Service Systems

The purpose of this proposition is not simply to convince practitioners or policymakers to adopt a culturally anchored service approach. Virtually all current health and human services are anchored in a cultural framework, particularly those dealing with issues of prevention, intervention, and treatment. The dilemma is that they are anchored in elements of the mainstream culture that, at best, connect only tangentially with the cultural roots and norms of African-American clients and communities; further, as discussed earlier, these services have often had a corrosive effect on the very community systems and individuals they were designed to help. The need, therefore, is to have systems of service that are anchored in the social and cultural ecology of the communities they serve. Furthermore, such approaches must become a basic standard for effective professional practice for nonmainstream communities and clients.

However, these changes must go beyond culturally specific or appropriate programs to more fundamental alterations in the entirety of the organizational, operational, and policy assumptions, principles, and constructs for the health and human services enterprise as a whole. More specifically, a culturally anchored approach to designing and providing services must not just incorporate strategies for ensuring that all staff are culturally sensitive and competent. Rather, all services should be grounded in a recognition of the following: (1) Individual or community dysfunction is at least as much a function of disruption, dislocation, or corruption of core cultural structures as it is the result of any social or personality pathologies that are at the heart of traditional constructs for psychology, social work, or psychiatry. (2) An explicit goal for these services should include enhancing, strengthening, or rebuilding critical cultural structures and knowledge at both the individual and community levels. (3) Developing designs for culturally anchored service systems requires the ability to think systemically—that is, to move beyond focusing only on specific arenas of professional practice to a broader understand-

ing of the social and political contexts in which that practice occurs.

In particular, there is a need for prevention, treatment, and other health and human service providers to recognize the broader implications of these issues beyond discussions about professional practice. The national conversation about the importance or impact of context and culture comes at a time when America is struggling with the entire matter of diversity—a debate that has inflamed the passions of policymakers, service providers, researchers, and the public at large.

On one side are those who advocate the critical importance of increasing attention to culturally appropriate or "context responsive" social policy and services. On the other side are those who have dismissed the cultural diversity debate as simply the latest manifestation of political correctness or, more cynically, as a way for some groups to excuse their inability to compete or succeed in the mainstream. For example, in "The End of Racism," D'Souza (1995) proposes that "what blacks need to do is to 'act white,' which is to say, to abandon idiotic Back-to-Africa schemes and embrace mainstream cultural norms, so that they can effectively compete with other groups." Some even assert (sometimes from an aggressive, even hostile posture) that the entire focus on diversity is at the heart of America's social problems, that is, that the very debate itself is sowing seeds of division and conflict (see Hughes, 1992, 1993).

Even further, the recent publication of such books as "The Bell Curve" (Herrnstein & Murray, 1994), "Race, Evolution, and Behavior" (Rushton, 1995), and "The End of Racism" and the accompanying media attention have reintroduced (and will likely continue to inflame) the debate over whether or not intelligence and behavior (and, by implication, pathology) are primarily the result of genetics, rather than environment. While this debate is not new, its reemergence at this time further complicates discussion of cultural foundations for service delivery. At the same time, it requires that African-American researchers, as well as those who provide or are concerned about the efficacy of prevention, treatment, and other health and human services in the African-American community, become far more visible and

aggressive participants in the political and professional aspects of the dialog.

Redefine the Concept of Health

Generally, discussions of health focus narrowly on the prevention or treatment of specific physical or mental problems and, therefore, primarily on the institutions or systems that provide such services. However, as one reviews the challenges facing the African-American community today, such a narrow delineation is no longer adequate. If we are going to substantially improve the overall well-being of African Americans, the term "healthy" must be applied to the community environment as a whole, not simply to individuals.

For example, the 1986 Ottawa Charter for Health Promotion states, "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites" (cited from Terris, 1994). Similarly, Thomas (1992) noted "the health status of the Black community is tied to the role Black Americans play in the nation today *and the role they will play in the future*" (emphasis added). He further suggests that health status disparities manifest themselves in school failure and an inability to participate fully in the workforce—factors that contribute to the persistence of an underclass suffering disproportionately from disease and disability. Health, therefore, must be seen not simply as an outcome measure but as an enabling factor that will contribute to the ability of Black Americans to participate fully in America's future.

These perspectives suggest that a critical element of the paradigm shifts we will need is the redefinition of what we are trying to achieve; in other words, what is our vision and criteria for the success of our critical community and societal institutions, not simply for success with individual clients? In the case of the African-American community, we must focus more on strengthening or rebuilding those cultural structures within the "village." Historically, the structures equipped both our communities and

people to prevail in the face of even the most aggressive attempts to prevent them from doing so. In particular, we must rebuild those cultural traditions that focused on critical relationships, shared responsibilities, personal and institutional anchors, developmental pathways or rites of passage, and a sense of joined or interdependent destinies.

The key principle here is that proactive involvement in strengthening or rebuilding core cultural structures, foundations, and support systems must become at least as central to the goals of health and other human services institutions as the current priority of responding to specific problems, funding, or the most apparent or manufactured crisis. In addition, there is a critical need to develop a more powerfully and systematically organized compilation of research that can provide the basis for both political advocacy and community education and partnerships. The challenge is to find the critical points of intervention, leverage, and influence in both health and human services institutions and programs and the community. The challenge is also to find the political structures that can provide a foundation for rethinking the basic service paradigm or for creating entirely new service structures. In fact, while there is much concern in the African-American community and among African-American service providers about current proposals for new funding arrangements at the State and Federal levels, such proposals could provide points of intervention that could support the development of new models for culturally anchored prevention, treatment, and other health and human services. Again, careful study and proactive advocacy must replace simply reactive opposition.

Focus on Community Vulnerability Rather Than Individual Pathology

This proposition revolves around the concept of individual, social, and community vulnerability as a more appropriate and powerful metaphor for assessment and intervention than the traditional doctrine of pathology. As mentioned earlier, the available evidence suggests that the depth and breadth of challenges facing African-American and other communities can be more con-

structively understood as the result of a breakdown in cultural and social immune systems, rather than the spread of individual pathologies, even though some individuals may present apparent or real pathological symptoms. In this view, like the body, once the immune system has been weakened or overwhelmed, it becomes vulnerable to a variety of contagious or opportunistic diseases.

In many African-American communities, the pattern of disruption of critical cultural structures has so weakened the social and cultural immune system that both the individual's and the community's capacity to withstand the pattern of political, social, economic, and cultural assaults has seriously deteriorated. Again, as with a biological system, the need is not simply to treat the symptoms or even the disease, but to simultaneously rebuild the capacity of individual and related community immune systems to both maintain health and withstand future assaults.

It is from this perspective that the concepts of cultural structures and culturally anchored services provide more promising options and possibilities for successful prevention, intervention, and treatment than current strategies. The current strategies may well suppress symptoms or even remedy a specific problem, but typically they do not rebuild the overall immune system, leaving the individual or community still vulnerable. The following examples illustrate positive approaches to the problem of vulnerable cultural and social immune systems:

- In the May 1994 journal *Adolescence*, Linda Washburn talks about attempts to rebuild family structure as a means of addressing increased teenage violence.
- In the March 1995 *Atlantic Monthly*, Paul Robinson suggests that "moral authority, rather than rehabilitation or deterrence" may be our best strategy for reducing violent crime.
- The Commission on Teacher Credentialling October 1995 "Final Report on Recommendations for Reducing Violence in California Schools" is titled "Creating *Caring Relationships* to Foster Academic Excellence" (emphasis added).

In each case, the focus has far greater implications for rebuilding cultural structures and immune systems than simply for creating

more sophisticated strategies of classification and categories of dysfunction and treatment. The next propositions focus on some of the key principles that should guide this undertaking.

Empower Rather Than "Fix" People

Empowerment contradicts much of the philosophy of current health and human services, particularly in the areas of prevention and treatment. The majority of these strategies are still organized primarily around fixing specific problems and are focused more on what we do not want people to do, rather than on what we want to help them become. Success is tied to reduction of the specific problem behavior or pathology, or at least reduction of the most visible or problematic symptoms. The dilemma of this approach is that being problem free is not the same as being prepared or empowered to live a purposeful or productive life (Pittman, 1992). For groups that have been disempowered in and by the larger society, it is even more important to help them move beyond solving immediate problems. Instead, we must help rebuild their entire vision of who they are and who they can become, their capacity to take control of their lives and the circumstances they confront, and their ability to construct positive pathways toward a productive future.

The problem-based approach also tends to reflect America's cultural priorities regarding the individual rather than the collective group, and deficit remediation as opposed to competency development. These priorities are both in contradiction to traditional African cultural values and, for that matter, historic American values. The notion that success in early America was simply a function of individual effort is a constructed illusion. From the earliest settlements, barn raisings, wagon trains, and cattle drives, to the communities some of us remember from our own childhood, the communal aspects of American life have been far more in evidence than the individualistic, selfish portrayals that underlie much of the current political rhetoric (Coontz, 1992).

None of this is to say that individuals do not have problems they need to solve. But for health service providers to focus simply on solving problems or, in some cases, merely reducing their

visible symptoms is an insufficient and sometimes even harmful goal. For example, in many programs designed to reduce youth violence, the goal is to help youths learn how to solve conflicts peacefully. Most would agree that this approach is productive. But it does not necessarily result in the youths being empowered to either recognize or take advantage of important opportunities in their lives, or to create such opportunities. For instance, in talking about adolescent drug abuse, Stanton Peele (1986) observed, "The mission of those concerned with adolescent drug abuse is to create a *cultural environment* [emphasis added] that encourages children to achieve independence, adventure, intimacy, consciousness, activity, self-reliance, health, problem-solving capabilities, and a commitment to the community. There is no better antidote for drug abuse than adolescents' beliefs that the world is a positive place, that they can accomplish what they want, and that they can gain satisfaction from life."

In the contemporary African-American community, empowerment must also include strengthening or reconstructing an understanding and a sense of connectedness to African heritage and cultural traditions. It is no longer adequate to simply help individuals resolve their immediate problems. They must also develop a sense of responsibility for assisting in the empowerment of the community, as well as African Americans as a whole, particularly in terms of pride in who they are and the heritage from which they come, and a commitment to the well-being of the entire African-American village.

Build on Strengths

"Strengths building" is a spinoff of the overall empowerment paradigm. Again the point is that we both develop the capacity to look beyond overt behavior and recognize internal strengths, and that we shift our priority from fixing problems in the present to developing competencies for the future. The fact is that you cannot build on what people do not know, cannot do, or on who they are not—you must always start from where they are, what they know, and what they can do.

To some this may seem merely rhetorical gymnastics; but in truth, it reflects a fundamental shift in the pathology paradigms that drive most mainstream clinical and community-based interventions. In particular, it is a shift from the traditional reliance on needs assessment and problem identification as the basis for program planning and development. While these strategies may at times be useful, they have several serious shortcomings.

One shortcoming is the pattern of having both the service provider and the client or community focus on what is wrong rather than on the resources on which to build. The typical result is that both parties tend to view themselves from a negative perspective. Another shortcoming is that these approaches tend to focus attention on communities or individuals only after problems have become clearly evident. Such an approach is often at odds with a more proactive preventive strategy, particularly one designed to focus on strengthening or rebuilding core cultural structures that can act as buffers (immune systems) against the onset of such problems in the first place.

From the therapeutic community, the concept of narrative therapy adds an important dimension to this discussion, with particular implications for culturally anchored approaches. "Instead of looking for flaws in people's psyches, 'narrative therapy' works at nurturing their *forgotten* strengths" (Cowley & Springen, 1995). Cowley and Springen quote therapists from Berkeley, California, who observe that "a 'problem-saturated' dominant story tends to 'filter problem-free experiences from a person's memories and perceptions' so that 'threads of hope, resourcefulness, and capability are excluded from a person's description of self.'" Many African-American clients and communities are so consumed with the problems and negatives of their current state that they (and often the therapist) lose sight of the fact that they have had, or still have, capabilities, competencies, and strengths on which they can build. In many cases, those positive attributes can only be identified once clients and communities reconnect their present perceptions of self with their heritage.

Enhance Personal and Social Anchors

The focus of this proposition is on the importance of enhancing or, in some cases, reconstructing core frameworks of knowledge, belief, and patterns of experience. We all use these frameworks to develop our sense of who we are, of how and by whom we are valued, and, more important, of where we fit into our immediate world as well as society at large. In the case of African Americans, particularly our young people, these anchors have often been influenced more by a socially toxic mass culture than by positive and important people in their lives, or by an understanding of the cultural traditions from which they come and an accurate history of who they are. If individuals believe that they come from nothing, are insignificant, and do not fit anywhere, then two patterns tend to emerge: First, they place little value on protecting or taking care of themselves; second, they have little interest in or respect for the values, mores, and sanctions of the people, institutions, or the larger society from which they are estranged.

These patterns have two implications for prevention and treatment: First, a culturally anchored approach is as much a process of education, knowledge reconstruction, and spiritual development as it is a clinical intervention. Second, helping people build meaningful and socially and culturally positive connections with others—as mentors, for example—is often a far more powerful intervention than any traditional clinical strategy. In fact, the search for such anchors and the sense of attachment and belonging they represent is at the heart of much of the initial involvement in gangs by young and older people alike. Similarly, the precursor for many people's involvement with drugs is that drugs provide a ticket of entry or membership to a social group.

Consider, for example, the following quotes by Mark Mathabane in "Kaffir Boy," a book about his life growing up in South Africa. Mathabane discusses his frustration and growing disaffection with his school experience, coupled with the lack of support from his father, who never had the opportunity to become educated and who found little value in the "white man's" education:

Hearing all this talk confused me even more about the objectives of what I was learning. Yes, I was coming out at the top of my class—yes, I could read and write things in Tsonga [the official language in schools for Blacks]—yes, I could recite arithmetic tables—yes, I knew how to draw the map of Alexandria [the Black South African ghetto in which he grew up]—yes, I could sing hymns and recite scriptures ... but what did it mean?

Hardly three years after I had begun school, the novelty of learning began to fade. Despite my continued success in school, I failed to find any real meaning in what I was being taught; more important, I failed to find, among the Black people I lived with, and with whose accomplishments in life I was familiar, those particular individuals whom I could identify as having benefitted from an education, and whose accomplishments in life could act as landmarks to orient me and help me set goals in life. Where were the lighthouses to guide my newly built ship of knowledge just setting sail on a perilous journey upon a vast, turbulent and unknown ocean of life?

Foster Relationships and Personal and Social Support Systems

This key principle is tied to the concept of personal and social anchors, but goes beyond the individual to the cultural spirit of families, communities, and service delivery organizations and agencies. Although the African proverb, "It takes a whole village to raise a child," has almost become a cliché, its fundamental truth remains for the type of personal relationships and social support systems necessary for the healthy growth and development of children, adults, and families.

I mentioned earlier the myth of individualism that has been adopted by many adults in our community, who have apparently forgotten the networks of support most of us had available both as children and as adults, within and beyond our families. Helping clients find pathways back to productive and positive lives requires that we engage in broadly collaborative efforts to reestablish the village concept in our institutions and neighborhoods,

especially for our children. If we don't take time to be our brothers' and sisters' keepers in the present, we may well become their victims in the future. This sense of place, of belonging, is a crucial building block for the healthy development of children and adolescents, and I would add adults and families.

Expand Personal Visions of Possibilities

This proposition extends the focus of the earlier principle of building on strengths in two ways: First, health service providers should help people not only recognize the strengths and capabilities they have but also connect them to the people who can help them recognize how to translate their strong points and interests into a meaningful, productive, positive, and profitable career or entrepreneurial enterprise. Second, health service providers should help people focus on what they can become. This focus on "becoming" is a critical element in effective prevention and treatment strategies. The critical question involved here is not why people get involved in various personally and socially destructive behaviors, but why more people don't. In most, but not all, cases those who have avoided the traps have typically had a sense of purpose and a vision of their possibilities that was sufficiently powerful to prevent them from jeopardizing or abandoning the purpose or vision by becoming involved in a destructive pattern of behavior.

For African-American clients and communities, the process of creating the sense of purpose and possibilities often requires more than a linear logical discussion of what they are risking by their behavior. Instead, it typically involves helping the individuals or the community rebuild the view of the roots from which they come, providing them with opportunities to experience new possibilities for what they can become, and helping them to both understand and strengthen their social, cultural, and community immune structures. The success of personal journey programs such as Outward Bound, or even the simple act of growing things, is testimony to the power of rebuilding visions as a tool for personal and social development, as well as a modality for individual treatment.

Another aspect of this process revolves around helping people and communities construct developmental pathways from where they are to where they would like to be (as opposed to where they expect to be). Here, the African tradition of rites of passage is particularly appropriate. Health care is not simply a progression through stages of treatment or prevention; rather, it is a personally empowering and truly meaningful journey of personal discovery, service to others, connectedness to key institutions and support systems, and perhaps most important, the opportunity to develop an expanding sense of being valued, important, and embraced by the community.

Identify the Most Appropriate or Powerful "Point of Intervention"

More important than the prevention strategy or treatment protocol for both individuals and communities as a whole, the point of intervention is simply that place where one can best connect with and leverage the strengths, resources, networks, attention, and trust of either a community or an individual. How an individual client is introduced into a clinic or program, or to a service provider; or how a health and human services institution is introduced into the community are critical factors in helping establish legitimacy and trust. With legitimacy and trust, one more easily may be able to identify the point of intervention that will be most effective for that particular case or situation.

Watch Out for Potholes

The issue of diversity in general, as well as the pathway to developing culturally anchored services and strategies, is neither simple nor linear. As has been noted, there are typically many distractions, controversies, and frustrations along the way. It is important that we be aware of these potholes so that we can recognize them for what they are and not allow them to distract us from our intended destination. Based on my personal and professional experiences, the following are some of the most common of those dangers:

- *Cultural arrogance* from any direction can often push one either to defending a status quo that is not sufficiently respectful of those not included in the American mainstream (however defined), or, equally problematic, to adopting the mainstream posture of superiority of one's own cultural roots over those of others. In either case, problems are exacerbated, not solved.

- *Valuing color over competence* is another danger to be avoided. While it is important that all agencies serving culturally diverse populations and communities hire staff who are both members of and in tune with those cultures and communities, we must be careful not to fall victim to the trap of accepting symbolism over substance. Appearances may serve a temporary purpose. However, in the case of health and human services delivery, bad practice will result in destructive outcomes, regardless of the cultural heritage of the practitioner. We must also be careful not to define competence as simply the traditional credentials that, taken alone, have proven to be wholly inadequate.

- *Putting survival ahead of integrity* is one of the most difficult of the potholes any professional or agency may encounter. Yet if our goal is truly to provide the best and most appropriate service possible to our clients and communities, then we must be fully honest about how successful we have been, not simply how hard we have worked, or the degree to which we have met the service delivery requirements of our funding source. The critical questions are these: Do we accept funding that requires us to continue service delivery strategies that are not working? Or do we continue to solicit funding to maintain our jobs, regardless of our success rate with our clients? These are indeed difficult questions, but ones that need to be included in our conscious discussion about what, why, and in whose interests we are acting.

- *Hiding behind racism* is another subtle and seductive trap. The challenge here is to differentiate between the very real racism (and for that matter classism and sexism) that continues to permeate much of American society, and the claim

of racism whenever there is a conflict or disagreement among staff, clients, or partners from different racial or ethnic groups. Every criticism or difference of opinion from White staff, for example, is not necessarily grounded in racism, nor is every opinion or belief of minority staff grounded in truth. Again, this issue is very sensitive and potentially explosive and divisive, requiring serious attention as well as sensitivity and trust among agency staff, management, clients, and the community. The challenge is to prevent honest differences from becoming intractable and infectious divisions.

- *There is no magic bullet* is the final pothole I will discuss in the context of this chapter. While it is true that we have much knowledge about culturally appropriate or competent service design and delivery, the truth is that there are no single approaches that are universally applicable for all agencies, clients, and circumstances. The issues of diversity in contemporary America are simply too complex and varied to be accommodated by a single model. There are some principles, perspectives, knowledge, and understandings that are generally applicable. These can be used to frame development of specific strategies to meet the needs of clients and communities. However, the search for an easy universal approach is ultimately a fruitless one.

Conclusion

This chapter has proposed a set of propositions that may be useful in stimulating your thinking and providing frameworks for examining ways to incorporate these perspectives into your professional practice, as well as in your agencies or programs.

The lessons and messages of this narrative are quite simple and in many ways reflect a return to traditional African-American principles and traditions, rather than a discovery of new ideas. Culture and context are not just issues around the periphery of our efforts—they must, I believe, become the core of those efforts. They must become the foundations on which we build new strat-

egies and frameworks for addressing the increasingly diverse and complex needs of children, families, and communities, and for rebuilding the cultural infrastructures and relationships that will ensure their healthy growth, development, and well-being. This task is neither a simple nor an easy one. Nonetheless, it must become our mission and our responsibility—for our children, ourselves, and the future we will share. I leave you with one final thought:

> *I refuse to accept the idea that the "isness" of man's present nature makes him morally incapable of reaching up for the "oughtness" that forever confronts him (Martin Luther King, Jr., Nobel Prize Acceptance Speech, 1963).*

This is our challenge; our choice is whether we will accept it.

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2

Contours of the African-American Culture

Molefi Kete Asante, Ph.D.

Introduction

African Americans constitute the largest non-European racial group in the United States. Africans came to the area that became the United States in the 16th century with the Spaniards. However, the first appearance of groups of Africans in the English colonies of America occurred in 1619 when 20 Africans were brought as indentured servants to Jamestown, Virginia. Subsequent importations of Africans from Western Africa stretching from Morocco in the north to Angola in the south over a period of 200 years greatly increased the African population in the United States. By time of the Emancipation Proclamation in 1863, the population of Africans in the United States had reached 4.5 million.

A composite people, composed of numerous African ethnic groups—including Yoruba, Wolof, Mandingo, Hausa, Asante, Fante, Edo, Fulani, Serere, Luba, Angola, Congo, Ibo, Ibibio, Ijaw, and Sherbro—African Americans have a common origin in Africa and a common struggle against racial oppression. Many African Americans show evidence of racial mixture with American Indians, particularly Muskogee, Choctaw, Cherokee, and Pawnee as well as with Europeans from various ethnic backgrounds.

The Great Urban Migration

African Americans were predominantly a rural and southern people until the great urban migration of the World War II era. Thousands of Africans moved to the major urban centers of the North to find better jobs and more equitable living conditions. Cities such as Chicago, New York, Philadelphia, and Detroit became magnets for entire southern communities of African Americans. The lure of economic prosperity, political enfranchisement, and social mobility attracted many young men; often, women and the elderly were left on the farms of the South. Husbands frequently would send for their wives, children, and parents once they were established in their new homes in the North.

Residential segregation became a pattern in the North as it had been in the South. Some of these segregated communities in the North gained prominence and became centers for culture and commerce. Harlem in New York, North Philadelphia in Philadelphia, Woodlawn in Detroit, Southside in Chicago, and Hough in Cleveland were written into the African American's imagination as places of high style, fashion, culture, and business.

African-American Populations in the 1990s

The evolution of African-American communities from southern and rural to northern and urban areas has continued since 1945. According to the latest 1990 census, the largest populations are found in these cities: New York; Chicago; Detroit; Philadelphia; Los Angeles; Washington, DC; Houston; Baltimore; New Orleans; and Memphis. In terms of percentage of population, the following five cities are the leaders among cities with populations over 300,000: Washington, DC (70 percent); Atlanta (67 percent); Detroit (65 percent); New Orleans (55 percent); and Memphis (49 percent). East St. Louis, Illinois, is 96 percent African American; however, its population is less than 100,000.

New York has the largest population of African Americans, with 2.1 million; Chicago ranks second with 1.4 million, followed

by Detroit (approximately 800,000), Philadelphia (approximately 700,000), and Los Angeles (approximately 600,000).

Seven States have African-American populations of more than 20 percent: Mississippi (35 percent), South Carolina (30 percent), Louisiana (29 percent), Georgia (27 percent), Alabama (26 percent), Maryland (23 percent), and North Carolina (22 percent).

The 1990 population of African Americans is estimated to be 35 million. In addition to the U.S. African-American population, there are approximately 1 million African Americans abroad, mainly in Africa, Europe, and South America. African Americans constitute about 12 percent of the American population, which is roughly equal to the percentage of Africans in the populations of Venezuela and Colombia. The largest population of African people outside of the continent of Africa resides in Brazil. The United States has the second largest population of Africans outside of the continent of Africa. Nigeria, Egypt, Ethiopia, and Zaire join the United States and Brazil as the countries with the largest populations of Africans in the world.

African Americans and the English Language

African Americans are now avid speakers of English. During the 17th century most Africans in the Americas spoke West African languages. In the United States, the African population developed a highly sophisticated pidgin, usually referred to by linguists as ebonics. This language was the prototype for the speech of the vast majority of African Americans. It consisted of African syntactical elements and English lexical items. Use of this language made it possible for Africans from various ethnic and linguistic groups, such as Yoruba, Ibo, Hausa, Akan, Wolof, or Mande, to communicate with each other as well as with the Europeans with whom they came into contact. The impact of the African-American idiom on American society is thorough and all-embracing. From the ubiquitous "OK," a Wolof expression from Senegal, to the transformations of simple English words such as bad and awesome into different and more adequate expressions of something

entirely original, one sees the imprint of African-American styles that are derived from the African heritage. There are more than 3,000 words, place names, and concepts with African origins found in the language of the United States. Indeed, the most dynamic aspects of the English language as spoken in the United States have been added by the popular speakers of the African-American idiom, whether in the world of words of contemporary rap musicians, of past jazz musicians, or of the street slang that gives American English its more authentic color. Proverbs, poems, songs, and hollers that derive from the historical saga of a people whose only epics are the spirituals, or the "great songs," provide a rich texture to the ever-evolving language of the African-American people.

From Africa to America

African Americans did not come to America freely. Their history is not one of a people seeking to escape political oppression, economic exploitation, religious intolerance, or social injustice. Rather, the ancestors of the present African Americans were stolen, or sold, from the continent of Africa, placed on ships against their will, and transported across the Atlantic. While most of the enslaved Africans went to Brazil and Cuba, a great portion landed in the Southern United States. At the height of the European slave trade almost every nation in Europe was involved in some aspect of the enterprise. As the trade grew more profitable and European captains became more ambitious, larger ships with specially built slave galleys were commissioned. These galleys between the decks were no more than 18 inches in height. Each African was allotted no more than a space 16 inches wide and 5½ feet long for the many weeks or months of the Atlantic crossing. Here, Africans were forced to lie down shackled together in chains fastened to staples in the deck. Needless to say, many Africans perished under such conditions. Where the space was 2 feet high, Africans were often allowed to sit with legs on legs like riders on a crowded sled. Africans were transported from Africa to America seated in this position with only a short daily break for exercise. Many died or went insane.

The North made the shipping of Africans its business; the South made the working of Africans its business. By 1860, the census counted 4.5 million Africans in the United States. This number increased rapidly during and after the 18th century. The African-American population grew both by increased birth rates and by importation of new Africans—from 757,208 in 1790 to 4 million in 1860. But by 1860, slavery had been virtually eliminated in the North and West. And by the end of the Civil War in l865, it was over for every State. After the Civil War, 14 percent of the population of the United States was African. The 4.5 million Africans who made up the Black population in 1865 are the ancestors of the overwhelming majority of Africans living in the United States today.

The Post-Civil War Era

During the Reconstruction Period after the Civil War, African-American politicians introduced legislation that provided for public education—one of the great legacies of the African-American involvement in the legislative process of the 19th century. Education has always been seen as a major instrument in changing society and bettering the life chances of African-American people. Lincoln and Cheney Universities in Pennsylvania, Hampton University in Virginia, and Howard University in Washington, DC, are considered some of the oldest institutions of learning for the African-American community. Other colleges and universities, such as Tuskegee, Fisk, Morehouse, Spelman, and Atlanta are now a part of the American educational story of success and excellence.

The Civil Rights Movement

The great civil rights movement of the 1950s and 1960s ushered in a whole new generation of African Americans who were committed to advancing the cause of justice and equality. Rosa Parks refused to give her seat to a White man on a Montgomery city bus and created a stir that would not end until the most visible signs of racism were overthrown. Martin Luther King, Jr., emerged as

the leading spokesperson and chief symbol of a people tired of racism and segregation and prepared to fight and die if necessary to obtain legal and human rights. Malcolm X took the battle one step further, insisting that the African American was psychologically lost and therefore had to find historical and cultural validity in the reclamation of the African connection. Thus, out of the crucible of the 1960s came a more vigorous movement toward full recognition of the African past and legacy. Relationships with other groups came to depend more and more on mutual respect rather than on African Americans acting like clients to other groups. Furthermore, African Americans expressed their concern that the Jewish community had not supported affirmative action, although there was in fact a long history of Jewish support for African-American causes. This accelerating demand for greater mutual respect from all groups, coupled with acceptance of the role of vanguard in the struggle to extend the protection of the U.S. Constitution to oppressed people, caused African Americans to make serious, legitimate demands on municipal and federal officials during the civil rights movement. Voting rights were guaranteed and protected, educational segregation was made illegal, and petty discriminations against African Americans in hotels and public facilities were eradicated by the sustained protests and demonstrations of the era.

Economic, Employment, and Social Patterns

A growing economy does not always mean that African Americans will be served by that growth. African Americans have been key components in the economic system of the United States since its inception. However, the initial relationship of the African-American population to the economy was based on enslaved labor. Africans were instrumental in establishing the industrial and agrarian power of the United States. Railroads, factories, residences, and places of business were often built by enslaved Africans. Now, African Americans are engaged in every sector of the American economy, although the degree of integra-

tion varies by sector. Many African Americans work in industrial or service occupations. Others are found in professional occupations; fewer, however, are found in small businesses. Thus, teachers, lawyers, doctors, and managers account for the principal professional workers. These employment patterns are based on previous conditions of discrimination in businesses throughout the South. Most African Americans could find employment in communities where their professional services were needed; therefore, the above-mentioned professional areas (and others that cater to the African-American population) provide numerous opportunities for employment.

During the past 20 years, the number of businesses opened by African Americans has increased. During the period of segregation, many businesses that existed solely for the convenience of the African-American population flourished. When the civil rights movement ended most petty discriminations, making it possible for African Americans to trade and shop at other stores and businesses, the businesses located in African-American communities suffered. There is now a greater awareness of the need to see African-American businesses become interconnected and interdependent with the larger American society.

A greater and more equitable role is being played by women in the African-American community. Indeed, many of the chief leaders in the economic development of the African-American community are, and have been, women. Both men and women from the majority of African-American homes have always worked, and during the time of enslavement, work was the principal activity of both men and women.

African-American marriage and kinship patterns vary, although most now conform to the patterns of the majority. Monogamy is the overwhelming choice of most married people. Because of the rise of Islam, there is also a growing community of persons who practice polygamy. Lack of marriageable males is creating intense pressure to find new ways of maintaining traditions and parenting children. Within the African-American population, one can find various arrangements that constitute family. Thus, people may speak of family, aunts, uncles, fathers, mothers, and children without implying a genetic kinship. However,

African Americans often say "brother" or "sister" as a way to indicate possible kinship. In the period of enslavement, individuals from the same family were often sold to different plantation masters and given the names of those owners, creating the possibility that brothers or sisters would have different surnames. Most African-American surnames are derived from this period. These are not African names; for the most part, they are English, German, French, and Irish names. Few African Americans can trace their ancestry back before the enslavement period. Those who can have often found records in the homes of the plantation owners or in the local archives of the South.

African-American Children and the Rights of Passage

African Americans love children and believe that those who have many children are fortunate. It is not uncommon to find families with more than four children. African-American children are socialized in the home, but the church often plays an important role. Parents depend on other family members to chastise, instruct, and discipline their children, particularly if the family members live in proximity and the children know them well. Socialization takes place through rites and celebrations, such as the *mfundalai* rights of passage, which grow out of either religious or cultural observances. With the emergence of the Afrocentric movement, there has been a growing interest in African patterns of socializing children.

Parents introduce the mfundalai rites of passage at an early age to provide the child with historical referents. Increasingly, this rite has replaced religious rites within the African-American tradition for children. Although it is called mfundalai in the Northeast, it may be referred to as "changing season rite" in other sections of the United States. In the past, this rite was performed in churches and schools: children had to recite certain details about heroines and heroes, or about various aspects of African-American history and culture, to be considered mature in the culture. Many independent schools have been formed to gain control over the

cultural and psychological education of African-American children. A distrust of the public schools has emerged during the past 25 years because African Americans believe that it is difficult for African-American children to gain the self-confidence they need from teachers who do not understand or are insensitive to the culture.

Age-appropriate youth clubs are popular; these drill teams and formal groups are often called street gangs if they engage in delinquent behavior. More often than not, these groups are healthy expressions of male and female socialization impulses. Church and community organizations seek to channel the energies of these groups toward positive socialization experiences. Numerous Afrocentric workshops and seminars are offered to group members to train them in traditional behaviors and customs.

African Americans and Current Discrimination

African Americans can be found in every stratum of the American population. In a little less than 130 years, African Americans who were emancipated with neither wealth nor good prospects for wealth have been able to advance in American society, despite the odds. Determined and doggedly competitive in situations that threaten survival, African Americans have had to outrun economic disaster in every era. Discrimination against African Americans continues in private clubs, country clubs, social functions, and in some organizations. Nevertheless, African Americans have challenged hundreds of rules and regulations that have tried to limit choice.

The National Association for the Advancement of Colored People (NAACP) and the Urban League have been major players in the battle for equal rights. These two organizations have advanced the social integration of the African-American population on the legal and social welfare fronts. The NAACP is the oldest and largest civil rights organization. Its history in the struggle for equality and justice is legendary. Thurgood Marshall, the first African American to sit on the Supreme Court, was one of the

organization's most famous lawyers. He argued 24 cases before the Supreme Court as a lawyer and is credited with winning 23. Although there is no official organization of the entire African-American population and no truly mass movement that speaks to the interests of the majority of the people, the NAACP comes closest to being a conscience for the Nation and an organized response to oppression, discrimination, and racism.

At the local level, many communities have organized committees of elders that are responsible for various activities within communities. These committees are usually informal; their function is to assist the community in determining the best strategies to follow in political and legal situations. Growing out of an Afrocentric emphasis on community and cohesiveness, the committees are usually composed of older men and women who have made special contributions to their community through achievement or philanthropy.

African Americans participate freely in the Nation's two dominant political parties (the Democratic and Republican parties). Most African Americans are Democrats, a legacy left by the era of Franklin Delano Roosevelt and the New Deal Democrats who effected a measure of social justice and respect for the common people. There have been more than 6,000 African-American elected officials in the United States, including the mayors of San Francisco, Detroit, Philadelphia, New York, Los Angeles, and Chicago. A former governor of Virginia is African American, and two African Americans have been United States senators, with one currently serving in Congress. Concentrated in the central cities, the African-American population has a strong impact on the political processes of older cities. Recently, the person who served as the national chairperson of the Democratic Party is of African-American heritage. Some of the most prominent persons in the party are also African Americans. The Republican Party has its share of African-American politicians, though not as large. Although a dream of leading strategists, there is no independent political party in the African-American community.

Conflict is normally resolved in the African-American community through the legal system, although there is a strong impe-

tus to use consensus at first. The idea of discussing an issue with other members of the community who might share similar values is a prevalent one within African-American society. An initial recourse when problems arise is to consult another person. No matter what the problem, the African American is most likely to call a friend for advice rather than call a lawyer. To some extent, the traditional African notion of retaining and maintaining harmony is at the heart of the decision to turn to friends first. "Conflicts should be resolved by people, not by law" is one of the adages that guides this decision.

African Americans and Religion

African Americans practice the three main monotheistic religions as well as Eastern and African religions. The predominant faith is Christian; the second largest group of believers accepts the ancestral religions of Africa—Vodun, Santeria, and Myal; and a third group of followers practices Islam. Judaism and Buddhism are also practiced by some people within the community. Without understanding the complexity of religion in the African-American community, one will not understand the nature of the culture. While the religions of Christianity and Islam seem to attract attention, the African religions are present everywhere, even in the minds of Christians and Muslims. Thus, traditional practitioners have introduced certain rites that have become a part of the practices of Christians and Muslims. African greetings and libations to the ancestors are heard at Christian and Muslim gatherings. Also, many of the practitioners of the African religions use the founding of Egypt as the starting date for the calendar. Thus, 6290 A.F.K. (after the founding of Kemet) is equivalent to 1990.

African-American people are spiritually oriented and gave American society spirituals and master songs. African Americans have woven religion into everything so that there is no separation between religion and life. Nevertheless, there is no single set of beliefs to which all African Americans subscribe.

Similarly, there is no wide acceptance of cremation in the African-American culture. The majority of African Americans choose burial over cremation. Funerals are often occasions of sad-

ness followed by festivities and joyousness. "When the Saints Go Marching In" was made famous by African-American musicians in New Orleans as the song to convey deceased African Americans to the other world. Sung and played with gusto and great vigor, the song summed up the victorious attitude of a people long used to suffering on earth.

Conclusion

In this chapter, I have presented the factors leading to the migration of Africans to America. I have discussed the enslavement era; the post–Civil War era; and the current composition, religious trends, and economic and social status of African Americans within the United States, as well as the forces guiding current racial discrimination. Nonetheless, there are powerful (though few) African Americans in high leadership positions, who have had a tremendous and positive impact on African-American culture. Such leaders are not, however, new to us. The birthday of Martin Luther King, Jr., January 15, and the birthday of Malcolm X, May 19, are two of the most important days in the African-American calendar. Kwanzaa, a celebration of first fruits, initiated by the philosopher Maulana Karenga, is the most joyous occasion in the African-American year. Kwanzaa is observed from December 26 to January 1; each day of that week is named after an important virtue. These important days of remembrance and celebrations serve to (1) further the cause of racial equivalence and the uniquenesses of diversity among all Americans, (2) celebrate the various contours of the African-American culture, and (3) tie together the numerous African ethnic groups in harmony and in peace.

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3

African-American Women: A Health Crisis Perspective

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Introduction

The proliferation of technological advances in medicine during the 20th century has been astounding. Unfortunately, the disappointing health status of African-American women has failed to match the spiraling health-related technological achievements of this century. Why? Multiple reasons are offered that shape these consequences. Among the most compelling reasons are factors such as institutional racism, diminished levels of education, socioeconomic deprivation, and lack of access to quality health care systems. The research literature has documented the social dynamics that have contributed to health problems among African-American women in many ways.

Life Expectancy

A careful examination of the health status of African-American women from 1900 to the present clearly shows the changing health trends in society as a whole and the disparities within this special population. Life expectancy in 1900 at birth for African-American women was 33.5 years compared with 48.7 years for White women, and in 1995, the ratio was 73.9 years to 79.6 years, respec-

tively. Table 1 shows the trends and disparities in mortality rates between African-American and White women.

Table 1. Trends in life expectancy at birth for White women and African-American women: 1900–1995

Year	African-American Women	White Women
1900	33.5*	48.7
1950	62.7	72.2
1960	65.9	74.1
1970	68.3	75.6
1980	72.5	78.1
1990	74.5	79.4
1992	73.9	79.8
1995	73.9	79.6

* Includes other minority women.

Source: National Center for Health Statistics (NCHS), 1997.

The table compares life expectancy between African-American and White women. From 1900 to 1990, life expectancy for all Americans increased by 28 years or 63 percent. For White women, it increased 30.7 years or 61 percent, and for African-American women, the increase was 41 years or 45 percent. In 1900, the gap in life expectancy was 15.2 years: African-American women had a life expectancy of 33.5 years compared with 48.7 years for White women. By 1950, the gap between African-American and White women was 9.5 years; by 1960, it had narrowed to 8.2 years; by 1990, the gap was 4.9 years; by 1995, the gap was reduced to 5.7 years. While life expectancy rates for African-American females currently remain lower than the rates for White women, by age 85 and over, African-American women tend to have lower mortality rates—the rates in 1995 were 13,331.0 per 100,000 for African-American women and 14,538.5 for White women (National Center for Health Statistics [NCHS], 1997). This difference is often called the "crossover effect." A contributing factor to the earlier age cohort differences could be that White women have health insurance. They thus can access health care systems at significantly higher rates than can African-American women, and have serious health problems detected sooner. African-American

women tend to lack sufficient health insurance coverage and frequently use hospital emergency rooms as a last resort for health care when serious health problems arise.

Leading Causes of Death Among African-American Women

It is important to examine the leading causes of death for African-American and White women. Evident in the life expectancy data is the wide discrepancy between the two groups. From the beginning of the century to the present time, the trend has remained the same: White women tend to outlive African-American women. Table 2 shows the leading causes of death among African-American women in the years 1950, 1990, and 1995. Trend data indicate that from 1950 to 1995, a 45-year span of time, the three leading causes of death among African-American women were the same as for White women: heart disease, cancer, and cerebrovascular disease (CVA) (NCHS, 1996 for 1950 data only; NCHS, 1997).

Table 2. Leading causes of death among African-American women

1950	1990	1995
1. Heart Disease	1. Heart Disease	1. Heart Disease
2. CVA	2. Cancer	2. Cancer
3. Cancer	3. CVA	3. CVA
4. Pneumonia/Influenza	4. Diabetes	4. Diabetes
5. Unintentional Injuries	5. Accidents	5. HIV
6. Diabetes	6. Pneumonia/Flu	6. Unintentional Injuries
7. Homicide	7. Homicide	7. Pneumonia/Influenza
8. Chronic Liver Disease	8. Chron. Obst. Pulmonary	8. Chron. Obst. Pulmonary

Source: NCHS, 1996, 1997.

Heart Disease

The leading cause of death among all Americans and African-American females is heart disease. There has been a dramatic decrease in the overall incidence of heart disease mortality

rates in the general population, notably from a decline in ischemic heart disease. However, a ratio disparity continues to remain for African-American females compared to White females. It was reported that during a 10-year period from 1970 to 1980, the mortality rate for African-American women was 50 percent higher than for White women. Similarly, during a 13-year window from 1980 to 1993, the gap between the heart disease mortality rate was even more disparate—67 percent (NCHS, 1996). White women experienced a higher declining mortality rate from heart disease than did African-American women. Table 3 shows differences in heart disease mortality rates by age cohorts from 1950 to 1995. African-American females age 15 and above die at a higher frequency than White females at the same ages across the age cohort spectrum. Further, marked differences in heart disease mortality rates are seen at the 35-to-44 age cohort, with African-American women having much higher rates than those found in the same age cohort of White women. In 1950, the rate for African-American women was 3 times that for White women. In 1995, the ratio was 2.6 times as high (NCHS, 1997). In contrast, a crossover phenomenon is observed for African-American women who reach age 75 and above in that they tend to outlive White women of the same age cohort.

Table 3. Heart disease mortality rates among African-American women by age: 1950–1995 (deaths per 100,000)

Age Cohort	Mortality Rate		
	1950	1980	1995
15–24	19.8	4.6	NR
25–34	52.0	15.7	NR
35–44	185.0	61.7	NR
45–54	526.8	202.4	143.1
55–64	1,210.7	530.1	384.9
65–74	1,659.4	1,210.3	933.7
75–84	—	2,707.2	2,163.1
85+	—	5,796.5	5,614.8

NR = Not reported in NCHS, 1997.

Sources: NCHS, 1996, 1997.

Breast and Lung Cancer

The second leading cause of death among African-American females is cancer. From 1973 to 1992, White women experienced an incidence of breast cancer that was 12 percent to 29 percent greater than the rate for African-American women. In contrast, African-American women were dying at a rate 28 percent greater than the rate for White women (NCHS, 1996). The death rate for breast cancer in 1950 was 22.5 per 100,000 for White women and 19.3 per 100,000 for African-American women, with the highest mortality rates occurring at age 44 and above for both groups. White women experienced gradual declines from 1980 to 1993 for the critical age groups between 35 and 54 years. While breast cancer mortality rates peaked in 1995 for African-American women ages 35 to 54, the numbers were consistently higher than the rates of White women during this period (NCHS, 1997). Table 4 describes breast cancer mortality rates for both groups for 1950 and 1995.

Table 4. Breast cancer mortality rates among African-American and White women by age: 1950 and 1995 (deaths per 100,000)

Age Cohort	African-American Women		White Women	
	1950	1995	1950	1995
35–44	21.0	23.1	20.8	14.1
45–54	46.5	62.6	47.1	39.2
55–64	64.3	88.8	70.9	68.7
65–74	67.0	117.3	96.3	103.9
75–84	—	151.6	143.6	143.0
85 +	—	198.6	204.2	205.9

Source: NCHS, 1996.

Lung cancer is the most common form of cancer diagnosed in the United States. From 1973 to 1992, the incidences of lung cancer surged 134 percent, with an average annual rate of increase declining from 7.9 percent between 1973 and 1977 to 1.3 percent between 1988 and 1992. Between 1980 and 1988, lung cancer was one of the leading causes of cancer deaths among women. Mortality rates for cancer increased by 36 percent for White women

and 26 percent for African-American women. Lung cancer death among women has risen 600 percent during the last 30 years (Women's Health, 1988). Mortality rates for lung cancer were similar for ages 25 to 34 during the period of 1950–95. A dramatic increase of 182 percent was reported for all women during the years 1970–88, putting mortality rates for lung cancer higher than mortality rates for breast cancer deaths, and making it the leading cause of death from cancer among women (NCHS, 1996).

In 1990, it was estimated that 157,000 new cases of lung cancer occurred, accounting for 15 percent of all new cancer cases. One-third of the cases were among females (NCHS, 1992). Among African-American women, the incidence rate of lung cancer was 10 percent lower than for White females. Moreover, the rates were closely aligned—31 per 100,000 for White females and 28 per 100,000 for African-American females (NCHS, 1991) (see table 5).

Table 5. Lung cancer mortality rates among African-American and White women by age: 1950 and 1995 (deaths per 100,000)

Age Cohort	African-American Women			White Women	
	1950	1995		1950	1995
45–54	8.8	36.6		6.5	30.1
55–64	15.3	110.0		15.5	106.8
65–74	16.4	202.0		27.2	208.7
75–84	—	195.3		40.0	250.8
85+	—	171.4		44.0	188.4

Source: NCHS, 1991.

Tobacco is a factor in 90 percent of all lung cancer deaths. Both African Americans and Whites are smoking less than they used to; however, although African Americans smoke fewer cigarettes overall than Whites, they smoke cigarettes with more tar. Esophageal cancer rates among African Americans are 10 times higher than those for Whites (U.S. Department of Health and Human Services [USDHHS], 1987a). Cigarette smoking is the primary cause of this preventable disease in the country. Both African-American and White women continue to smoke cigarettes. There are 400,000 deaths per year from smoking, equivalent to 1,000 deaths per day. Smoking among the general population has

dropped significantly in the United States. A rising national concern, however, is the number of teenagers who are beginning to smoke cigarettes. A recent report showed that every day, 1,000 new teenagers start to smoke. However, African-American teenagers are not smoking at that high a rate, although they may eventually smoke cigarettes as adults. Between ages 12 and 17, females tend to smoke cigarettes at variable rates. Recent data show the declining trends in cigarette smoking of high school seniors from 1980 to 1990 (see table 6).

Table 6. Cigarette smoking among female high school seniors

Year	Percent Smoking Cigarettes in Past Month
1980	33.4
1981	31.6
1982	32.6
1983	31.6
1984	31.9
1985	31.4
1986	30.6
1987	31.4
1988	28.9
1989	29.0
1990	29.2

Source: NCHS, 1991.

The Surveillance, Epidemiology, and End Results (SEER) program of the National Cancer Institute, in a report citing data from 1973 to 1981, noted that African-American females and American-Indian females had the lowest five-year relative survival rates for cancer compared with Asian/Pacific Islander and Hispanic women. This was especially true for both breast and lung cancer; for African-American and Filipino women, survival was decidedly lowest. Both incidence and mortality rates for breast cancer were similar for African-American and White women per age-adjusted 100,000 population data from 1973 to 1981. Incidence and mortality rates for lung cancer among both African-American and White women tended to show parallel increases. African

Americans begin smoking at a later age and find cessation difficult (American Lung Association, 1997).

Cerebrovascular Disease

Mortality rates for cerebrovascular disease declined extraordinarily among all ages of African-American and White women from 1950 to 1993. Rates for African-American women declined from 155.6 in 1950 to 39.6 in 1995; similarly, mortality rates for White women declined from 79.7 in 1950 to 23.1 in 1995. The proclivity for cerebrovascular disease increases with age, and both groups exhibit the same pattern in the 45–74 age groups, with African-American women having a rate two to three times higher than the rate for White women. Marked decreases were shown among African-American women from 1950 to 1995 in age cohort 65–74 years, from 754.4 to 221.2, respectively; White women showed an identical pattern in the same age cohort, 498.1 to 112.6 (NCHS, 1997) (see table 7).

Table 7. Cerebrovascular mortality rates among African-American and White women by age: 1950 and 1995 (deaths per 100,000)

Age Cohort	African-American Women		White Women	
	1950	1995	1950	1995
45–54	248.9	36.4	55.0	12.7
55–64	567.7	85.5	156.9	33.6
65–74	754.4	221.2	498.1	112.6
75–84	—	583.2	471.3	449.5
85+	—	1,568.8	3,017.9	1,690.0

Source: NCHS, 1997.

Other Major Health Problems

Diabetes

Diabetes is the fifth leading cause of death in the United States. Women are twice as likely to have diabetes as are men. Diabetes is more prevalent among African Americans and low-income populations. Diabetics are at higher risk for stroke, heart attack,

and a variety of other potentially fatal conditions. Diabetes accounts for 300,000 deaths per year. Diabetes is 33 percent more prevalent among African Americans than among Whites. African-American women have 50 percent more diagnoses of diabetes than White women and are at even greater risk for the disease if they are obese. The death rate among infants born to African-American women with diabetes is three times that of White women with diabetes. Complications in diabetes, including stroke, kidney failure, and blindness, are more frequent in African Americans, and the mortality rates of diabetic African-American women is consistently higher than that of White women (USDHHS, 1987b) (see table 8).

Table 8. Diabetes mortality rates among African-American and White women: 1950–1993 (deaths per 100,000)

Year	African American	White
1950	22.7	16.4
1960	27.3	13.7
1970	30.9	12.8
1980	22.1	8.7
1985	21.1	8.1
1986	21.4	8.1
1987	21.3	8.1
1988	22.1	8.4
1989	24.6	9.6
1990	25.4	9.5
1991	25.7	9.6
1992	25.8	9.6
1993	26.9	10.0

Source: U.S. Department of Health and Human Services, 1987b.

Hypertension

Hypertension plays a major role in death from cardiovascular disease. Hypertension occurs in one in six Americans, one in four African Americans, and one in two African-American women (see table 9). African Americans die of hypertension at a rate twice that of White Americans (NCHS, 1992; USDHHS, 1985a, 1985b).

Increased hypertension rates contribute to a higher incidence of deaths from strokes, especially in African-American women. Problems with obesity, increased cholesterol levels, and smoking also contribute to elevated blood pressure levels. Each of these problems is preventable.

Table 9. Hypertension among women 20 years of age and over: 1960–1962, 1971–1974, 1976–1980, and 1988–1994 (percent of population)*

	1960–1972	1971–1974	1976–1980	1988–1994
All Races	39.0	39.7	39.7	23.1
White Female	34.9	34.9	34.2	20.4
Black Female	52.0	50.2	46.1	30.6

* Crude data—not age adjusted.

Source: NCHS, 1997.

Weight Disorders

More than 25 percent of women between ages 20 and 74 are considered overweight. It is estimated that of these, between 10 percent and 15 percent will die because of weight disorder complications. Table 10 provides an overview of the increase in body weight with age for women. This increase is particularly acute for African-American women. The weight index of African Americans ages 20–24 is twice as high as that of White women for the 20-year period, 1960–80. This pattern persists in other age cohorts as well. Increased weight with age for African-American women targets them for such health problems as high blood pressure, elevated blood cholesterol, diabetes, heart disease, stroke, some cancers, and gall bladder disease (NCHS, 1992). Data have already been shown in most of these disease categories. It is reported that more than half of women identified as overweight use diets, exercise, or both to reduce their body weight.

Table 10. Distribution by age of African-American and White women who are overweight*: 1960–1962, 1971–1974, and 1976–1980 (percent of population)

Age Cohort	1960–1962	1971–1974	1976–1980
African-American			
20–24	14.2	22.5	23.7
25–34	29.6	31.5	33.5
35–44	46.1	49.9	40.8
45–54	47.8	53.5	61.2
55–64	71.4	58.7	59.4
65–74	47.8	49.2	60.8
White			
20–24	6.7	9.1	9.6
25–34	13.9	15.9	17.9
35–44	20.9	24.5	24.8
45–54	28.2	29.9	29.9
55–64	40.1	36.6	34.8
65–74	42.8	37.0	36.5

* Overweight is defined as a body mass index greater than or equal to 27.3 kilograms per meter.

Source: NCHS, 1992.

Accidents and African-American Women

A growing public health concern is the number of unintentional injuries incurred by U.S. citizens. In this category, motor vehicle accidents account for the highest number of deaths and injuries. Almost 48,000 Americans died because of motor vehicle accidents during 1989, and it is estimated that 5.3 million individuals were injured because of the same. Alcohol is a major contributor to about half these incidents.

Homicide and Unintentional Injuries

Homicide accounts for more deaths in the United States than in any other industrialized nation. Homicide and unintentional injuries are two of the Nation's leading health problems, and there are major disparities between minorities and nonminorities. The USDHHS "1985 Task Force Report on Black and Minority Health"

projected that African-American males have a lifetime chance of 1 in 21 of dying from homicide. For White males, the ratio is 1 in 131. In 1989, when Black men are compared with White men, the data show that between ages 15 and 24, African-American men die at rates almost 10 times the rate of White men (114.8 and 12.8, respectively) (USDHHS, 1987c). Further, when African-American women of the same age cohorts are compared with White women, the rates are about 5 times as great for African-American women than for White women (17.3 and 3.9, respectively). African-American women are also dying at a rate 5 times that of White women in the age group 25–34. African-American women have a high risk of being homicide victims, and their lifetime survival rate is 1 in 104 compared with White women, whose homicide survival rate is 1 in 369. The task force reported that 50 percent of all homicides are related to alcohol and 10 percent are drug related (USDHHS, 1987c).

Homicide and unintentional injuries account for 35 percent of all African-American excess deaths under age 45, and 18.5 percent of excess deaths in African Americans under age 70. A large percentage is due to homicide and unintentional injuries.

Table 11 compares homicide and legal intervention death rates between Black and White Americans.

Table 11. Homicide and legal intervention deaths per 100,000 for African-American males and females

Population	1970	1980	1990	1995
Overall	9.1	10.8	10.2	9.4
White Male	7.3	10.9	8.9	8.2
African-American Male	82.1	71.9	68.7	57.6
White Female	2.2	3.2	2.8	2.8
African-American Female	15.0	13.7	13.0	11.0

Source: U.S. Department of Health and Human Services, 1987c.

Drugs and Homicide

Drug abuse is a factor in 10 percent of all homicides, and the rate is rising. Between 1982 and 1984, cocaine deaths among Whites doubled; in the African-American population, the rate tripled.

African-American drug users are more likely to combine cocaine with alcohol and other drugs. African Americans are three times more likely than Whites to be in treatment for drug-related problems. Hispanics are 2.7 times more likely to be in treatment for drug-related problems than non-Hispanics.

HIV/AIDS

While HIV/AIDS were not included in the USDHHS "1985 Task Force Report on Black and Minority Health," the almost epidemic increases have become both national and international priorities. About 80 percent of the reported cases of HIV infection result from either direct injectable drug use or heterosexual contact with a user of injectable drugs. Studies related to drug abuse and infants in New York and New Jersey report that for mothers aged 15–35, the leading cause of death among their infants was infection with HIV disease. Almost 80 percent of these infants are minorities.

The age-adjusted mortality rate of individuals with HIV increased by 32 percent during 1988 and 1989. HIV infection increased from the 11th to the 15th leading cause of death. Further, the HIV-related mortality rate for African-American women was nine times higher than that of White women (NCHS, 1991) (see tables 12 and 13).

Table 12. Human immunodeficiency virus (HIV) infection among Whites and African Americans: 1987, 1988, 1990, and 1995 (overall death rates per 100,000)*

Population	1987	1988	1990	1995
Overall	5.5	6.7	9.8	15.6
White Male	8.4	10.0	15.0	19.6
African-American Male	25.4	31.6	44.2	84.3
White Female	0.6	0.7	1.1	2.5
African-American Female	4.7	6.2	9.9	24.0

* These data are age adjusted. Patterns of transmission of HIV differ for males and females. In 1989, for African Americans and Hispanic females with AIDS, 77–81 percent of deaths resulted from either direct injectable drug use or from heterosexual contact with users of injected drugs. Heterosexual contact accounts for a large proportion of female AIDS cases.
Source: NCHS, 1991.

Table 13. Acquired Immunodeficiency Syndrome (AIDS) among Whites and African Americans: Number of cases

Population	All Years	1985	1990	1993	1995	1996*
All Ages	530,397	8,167	41,612	102,412	71,293	34,278
Females**	74,984	522	4,537	15,969	13,109	6,681
White	18,650	141	1,223	4,058	3,075	1,497
African Americans	43,253	280	2,543	9,109	7,671	4,071

* January to June 1996.

** All females 13 years and older.

Source: NCHS, 1991.

Suicide

The eighth leading cause of death in the United States is suicide. Suicide ranks third among individuals aged 15–24, and second among White males in this age group. In 1989, more than 30,000 lives were lost because of suicide in this country. It is reported that injuries due to firearms may have a major responsibility for death in this age group. Firearms-related deaths between 1984 and 1988 increased 31 percent among White youth and doubled among Black youth (USDHHS, 1987c). Suicide rates among White females have declined from 4.7 in 1986 to 4.4 per 100,000 in 1989, contrasted with increases in African-American female suicides from 2.3 in 1986 to 2.8 per 100,000 in 1989 (NCHS, 1992). The overall trend indicates that White males have higher suicide rates than African Americans regardless of gender (see table 14).

Table 14. Death rates for suicide among White and African-American males and females: 1950–1995 (deaths per 100,000)

Population	1950	1960	1970	1980	1990	1995
White Male	18.1	17.5	18.2	18.9	20.1	19.7
African-American Male	7.0	7.8	9.9	11.1	12.4	12.4
White Female	5.3	5.3	7.2	5.7	4.8	4.4
African-American Female	1.7	1.9	2.9	2.4	2.4	2.0

Source: NCHS, 1992.

Determinants of Healthy Behavior

An important concern in this review is the role of healthy behavior as a critical element in the reduction of mortality rates and increased morbidity among African-American females. Clearly, lifestyle, access to medical care, and environment account for 80 percent of those nonhereditary factors that determine health status. There is also an observable connection between mortality rates and lifestyle factors as related to high-risk behaviors, especially substance abuse, inadequate diet, and lack of exercise.

The shortage of culturally and linguistically appropriate services for African-American women (especially those for whom English is not the primary language) is also a significant issue that affects the overall health status of this population. The need to provide health services in linguistically and culturally appropriate ways is a universal one—we all have language (to understand and to be understood by others with whom we communicate)—and we all have culture (those shared beliefs, attitudes, values, and behaviors about health and illness shaped and influenced by our history, folklore, customs, traditions, and institutions). While many Americans receive linguistically and culturally appropriate health services as a matter of course, a sizable proportion do not. Those Americans whose language and culture of orientation are not within the dominant American mainstream (often ethnic and racial populations) experience severe health service disparities. Title VI of the Civil Rights Act of 1994 and the Disadvantaged Minority Health Care Act of 1990 mandate that the U.S. Department of Health and Human Services provide equal access to its programs and services to ethnic/racial/cultural populations and people with limited English skills.

Culturally and linguistically appropriate care is best achieved when organizations and people work closely with knowledgeable persons from the community to develop health care services that reflect the diverse values, traditions, and customs of clients. Cultural competency adds value to the health care delivery system by improving cost efficiency and quality of care (i.e., better outcomes, greater client satisfaction, greater profit margins, and enhanced value).

Cultural competence is inextricably tied to quality of care and is a crosscutting issue affecting *all* primary care services. Respect for cultural values, traditions, and customs affects the willingness and ability of individuals and organizations to develop interventions and services that affirm and reflect the value of different cultures. The extent to which interventions and services successfully affirm and reflect these values determines the appropriateness, acceptability, and accessibility of primary health care services. Clearly, these factors affect health status.

Health care providers working with African-American women must understand the cultures of the communities they are serving and must design and manage culturally competent programs that reflect these cultures. Culturally competent providers collaborate with culturally knowledgeable community members at every phase of program operation—design, implementation, and evaluation. Administrators, providers, staff, and clients work to enhance program integrity and clarify communication. The result is strong and sound interventions that lead to improved health outcomes.

When working with African-American women (or any ethnic or cultural population), health service delivery organizations should periodically conduct a self-assessment of their capacity to provide culturally competent services. The following are some questions that have proven useful in such a self-examination:

- **What is your organization's experience or track record of involvement with the community or communities served?**
  Does your organization have a documented history of positive programmatic involvement with the population or community to be served? Do your staff, board, and volunteers have a documented history of involvement with the target population or community to be served?
- **What types of cultural competency training has your staff attended, and what special qualifications does your staff have to work with the ethnic/racial/cultural/linguistic populations in your community?**
  Does your organization's staff have systematic, periodic, and followup training in cultural sensitivity and in specific

cultural patterns of the community serviced? Do you have staff who are prepared to train and translate community cultural patterns to other staff members? Are there clear, cultural objectives for staff and for staff development? Are these objectives actuated by a staff training plan that increases or maintains the cultural competency of staff members; and clearly articulates standards for cultural competency, including credibility in hiring practices, and calls for periodic evaluations and demonstration of the cultural and community-specific experience of staff members? Is emphasis placed on staffing the program with people who are familiar with or who are members of the community to be served?

- **Do you have diverse community representation?**
  Is the community targeted to receive services in all phases of program design? Is there an established mechanism to provide members of the target group with opportunities to influence and help shape the program's proposed activities and interventions? Is there an established community advisory council or board of directors of your organization with decisionmaking authority to effect the course and direction of the proposed program? Are members of the consumer cultural groups represented on the advisory council and organizational board of directors? Are the procedures for making contributions or changes to the policies and procedures of the project described and known to all parties?

- **If your organization provides services to a multilinguistic population, are there multilinguistic resources, including translators?**
  Are there printed and audiovisual materials sufficient for the proposed program? If translations from standard English to another language are to be used, is the translation done by individuals who know the formal structure and nuances of the language? Are all translations carefully pretested with the audience?

- **Materials**
  Are audiovisual materials, public service announcements, training guides, print materials, and other materials to be

used in the program culturally appropriate, or will they be made culturally consistent with the community to be served? Is pretesting with the target audience and gatekeepers conducted to provide feedback from community representatives about the cultural appropriateness of the materials under development?

- **Are program evaluation methods and instruments consistent with the cultural norms of the group or groups being served?**
  Is there a rationale for the use of the evaluation instruments chosen, including a discussion of the validity of the instruments in terms of the culture of the specific group or groups targeted for interventions? If the instruments have been imported from a project that uses a different cultural group, is there adequate evaluation and revision of the instruments so that they are culturally specific to the target group(s)? Are the evaluators familiar with and sensitized to the culture of your target group?

- **Does your plan appropriately target your service population?**
  Are there objective evidence/indicators in the initial program application and project work plans that show understanding of the cultural aspects of the community, that will contribute an understanding to the program's success? Does the program plan address how to recognize and avoid culturally related implementation pitfalls?

Conclusion

Clearly, the delineation of multiple health disparities affecting African American women presented in this chapter points to a profound need to increase access to health services for these populations. The concept of access to care involves the deployment of health services that meet the needs of patients in terms of location of services, flexible hours of operation, and cultural and linguistic access. The concept of access to services is a highly dynamic one. Services need to be responsive to the changing demographics of our patient populations. This responsiveness requires a re-

orientation of static conceptions of health services from a Western-oriented 9 to 5 clinic-based paradigm to a dynamic community-based outreach model of care that is more responsive to the cultural diversity of patient populations. Cultural competent models of care certainly hold the potential for improving current health disparities. We owe it to our ancestors, grandmothers, mothers, aunts, sisters, daughters, and those who are yet to be born, the inalienable right of full access to the highest quality, culturally and linguistically competent primary health care. We can ask for no less than this.

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4

The Protective Factor Model: Strengths-Oriented Prevention for African-American Families

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Introduction

Social indicators reveal that African-American individuals and families as a whole are not faring as well as others, particularly when compared with Whites. Nevertheless, the endurance and proliferation of African-American families in this society and the relative success of many of them, despite the violence and discrimination to which they have been subjected since colonial times, is testament to their inherent strengths and adaptive capacities. Although Billingsley (1968, 1988) and Hill (1972) have documented the strengths of African-American families, the prevailing paradigm for assessment and intervention with this group is problem focused and deficit oriented. African-American families are generally treated as flawed and dysfunctional units; little regard is paid to their strengths. Moreover, traditional treatment models are limited in that intervention is problem specific. Given the vulnerability of African-American families in this society, it is prudent to focus efforts on empowering them to cope effectively with the challenges they are likely to confront, thereby averting debilitating crises. Thus, a new paradigm is needed that combines concepts of prevention with a perspective of strengths.

The concept of prevention is the basis of the public health profession and has gained popularity in other disciplines including psychiatry and psychology in recent years. There are at least three conventional conceptual models of prevention research: the public health model, the communicable disease model, and the risk factor model.

The public health model incorporates the concepts of primary, secondary, and tertiary intervention. Each level of intervention is concerned with a different stage in the development of a problem behavior. Primary prevention aims to stop the problem behavior before the person engages in it. Secondary intervention is aimed at individuals who have engaged in gateway behaviors that may lead to full involvement. Tertiary intervention is directed at preventing those fully involved in the behavior from continuing their involvement.

The communicable disease model focuses on the concepts of host, agent, and environment. The host refers to a person's constitutional and lifestyle factors that influence his or her susceptibility or resistance to disease; the agent refers to cause or causal factors (i.e., the germ); and the environment relates to the social or physical factors that contribute to the initiation or spread of disease. The risk factor model is concerned with identifying psychological, social, and biological factors related to the emergence of a health problem (Buloski & Leukefeld, 1991).

These approaches to prevention have the same limitation as traditional health-oriented social work approaches in that they focus on alleviating a specific problem rather than increasing the overall capacity of a person or group to effectively cope with a variety of challenges they are likely to face. In response to these limitations, we propose a protective factor approach to prevention. This approach focuses on enhancing and supporting the inherent strengths of African-American families and developing additional resources to increase their resilience, that is, their ability to overcome adverse situations without being devastated in the process.

The protective factor model is based on research in the area of vulnerability and resilience (Rutter, 1987; Garmezy, 1985). Accordingly, protective factors are mechanisms that mediate or buffer

negative situational factors—risk factors—to prevent undesirable outcomes and promote positive outcomes. Protective factors do not prevent families from exposure to risk. Therefore, they do not indicate the absence of risk factors, nor are they the opposite of risk factors. Rather, protective factors help families successfully negotiate or interact with risk so that they are able to manage it effectively (Rutter, 1987). Thus, the concept of risk is important in this model because it indicates a family's level of vulnerability. However, rather than treat risk factors as the target for health-oriented social work intervention as in the risk factor model, the protective factor model focuses interventive efforts on enhancing the abilities of families to successfully negotiate risk situations.

The Vulnerability of African-American Families

African-American families experience inequities that place them at risk for negative outcomes in many domains including employment, income, and housing. Table 1 shows the median family income for Black and White families from 1971 to 1990. Black families earned $580 for every $1,000 earned by White families in 1990. The median income of Black families grew only 3.1 percent from 1971 to 1990, while the median White family income grew 7.2 percent.

Table 1. Median family income by race

Race	1971	1976	1981	1982	1986	1989	1990	Percent change
Black	20,783	21,229	19,074	18,417	20,993	21,301	21,423	3.1
White	34,440	35,689	33,814	33,322	36,740	37,919	36,915	7.2

Source: Bennett, C. (1994). *The Black population in the United States.* Washington, DC: U.S. Bureau of the Census.

Even when African Americans and Whites are matched on education levels, Whites earn more in most cases. The income gap is more pronounced among African-American men and White men than among African-American women and White women. Still,

African-American women only reach parity with White women at the "4 years of college" level. Although the disparities between African-American and White women are much smaller than those between African-American and White men, it must be noted that White women and African-American women earn significantly less than White men (see table 2).

Table 2. Earnings of Blacks per $1,000 for Whites by education level

Level of Education	Men	Women
>high school diploma	$797	$974
4 years of high school	$764	$942
1 to 3 years of college	$825	$925
4 years of college	$798	$1,002
5+ years of college	$771	$973

Source: Hacker, A. (1992). *Two nations: Black and white, separate, hostile, unequal.* New York: Ballantine.

The economic status of African-American families is further jeopardized by the consistently high unemployment rate among African-Americans. For each decade between 1960 and 1990, the rate for Blacks is twice that of Whites (or higher) suggesting that Blacks only get jobs when White workers have been accommodated (Hacker, 1992) (see table 3).

Table 3. Unemployment rates by year and race

Decade	Whites	African Americans
1970	4.4	8.2
1980	6.3	14.3
1990	4.5	11.4

Source: Hacker, A. (1992). *Two nations: Black and white, separate, hostile, unequal.* New York: Ballantine.

One explanation for the current high unemployment rate of African-Americans is that there has been a tremendous decline in the blue-collar jobs Black men have traditionally had access to, as cities have shifted from centers of production and distribution of material goods to centers of administration, information exchange, and higher order service provision. These shifts have occurred

primarily in older, larger U.S. cities, which tend to have higher concentrations of African Americans (Kasarda, 1990).

The Nation's 12 largest northern cities have lost hundreds of thousands of manufacturing jobs since the late 1940s (Kasarda, 1990). Service industries (e.g., barbershops, car washes, and domestic services) have also experienced substantial job losses. The expanding jobs in older central cities are in the information-processing industries. However, these expansions have not kept pace with the losses, thereby resulting in overall job losses. Thus, the total number of jobs available in these cities has declined considerably in the past 20 years (Kasarda, 1990).

Adding to the increased joblessness is the heightening educational requirements for employment. Educational requirements for the expanding employment sectors are higher than those for traditional inner-city jobs. Kasarda classifies jobs as entry-level if jobholders' average educational levels are less than high school completion; jobs are knowledge intensive if they employ persons whose average educational levels exceed 2 years of college. Many large U.S. cities have lost substantial numbers of jobs in entry-level industries while gaining large numbers of knowledge-intensive jobs (see table 4). However, African Americans have fared better in cities that have grown in both sectors, such as Houston, San Francisco, and Denver.

Table 4. Employment changes by average educational requirements for selected U.S. cities, 1970–1980

City	Entry Level	Knowledge Intensive
New York	−38.2	24.9
Philadelphia	−32.9	37.8
Baltimore	−32.4	20.6
Boston	−22.6	33.3
St. Louis	−18.2	−26.3
Atlanta	−12.1	35.6
Houston	73.8	119.4
Denver	14.5	91.4
San Francisco	−10.2	46.8

Source: Kasarda, J.D. (1985). Urban change and minority opportunity. In P. Peterson (Ed.), *The New Urban Reality* (pp. 53–67). Washington, DC: Brookings Institute.

Table 5 shows the changing nature of the Black labor force from 1960 to 1990. In 1960, the majority of Black men were blue-collar workers, and the majority of Black women were in service work. In the decades from 1960 to 1990, large numbers of African-American women moved out of service and into white-collar jobs. The number of African-American women in white-collar jobs increased by 217 percent during this period. African-American men also increased their numbers in the white-collar sector dramatically. The number of African-American men in white-collar jobs increased by 151 percent. However, in 1990, almost half of Black employed men were still working at blue-collar jobs, the very jobs that are decreasing in number. Thus, a large number of African-American men are at risk for unemployment.

Table 5. Employment of African Americans by sector, 1960–1990

	Year				Percent change	
	1960		**1990**			
Sector	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**
White collar	12.1	18.2	30.4	57.7	151	217
Service	25.1	66.6	21.3	27.8	−15	−58
Blue collar	62.8	15.2	48.3	14.5	−23	−5

Source: Hacker, A. (1982). *Two nations: Black and white, separate, hostile, unequal* (p. 233). New York: Ballantine.

Given the changing face of the job market, low educational attainment and lack of skills, particularly technical skills, by the primary wage earners in families are risk factors for unemployment. Table 6 shows that African-American men and African-American women are completing high school and college at the same rates, even though more African-American women are in white-collar jobs. This indicates that many white-collar African-American women probably hold the lower level, lower paying jobs in this sector. However, low-end white-collar jobs are likely to require more technological skills than higher paying blue-collar jobs held by African-American men. Thus, African-American women may be less vulnerable to unemployment than African-American men.

Table 6. Educational attainment of blacks by gender, 1960–1990

Years	Year						Percent increase	
	1970		1980		1990			
completed	Males	Females	Males	Females	Males	Females	Males	Females
≥ 4 years of high school	30.1	32.5	50.8	51.5	65.8	66.5	119	105
≥ 4 years of college	4.2	4.6	8.4	8.3	11.9	10.8	183	135

Source: U.S. Department of Commerce Economics and Statistics Administration, Bureau of the Census (1993). *Statistical abstract of the United States: 1993* (113th ed., p. 153). Washington, DC: Author.

In comparison to Whites, educational attainment among African-Americans is increasing more rapidly (see table 7). However, the percent of Blacks completing high school and college is still much lower than that for Whites. The percent of Whites completing 4 years of college or more is twice that of Blacks. This, combined with the overall shrinking numbers of jobs in cities, persistent racial discrimination, and the recent threats to affirmative action, increases African Americans' vulnerability in the areas of employment and income.

Table 7. Educational attainment by race, 1960–1990

Years	Year						Percent increase	
	1970		1980		1990			
completed	Blacks	Whites	Blacks	Whites	Blacks	Whites	Blacks	Whites
≥ 4 years of high school	31.4	54.5	51.2	68.8	66.2	79.1	110	45
≥ 4 years of college	4.4	11.3	8.4	17.1	11.3	22.0	157	95

Source: U.S. Department of Commerce Economics and Statistics Administration, Bureau of the Census (1993). *Statistical abstract of the United States: 1993* (113th ed., p. 154). Washington, DC: Author.

Inequity in access to housing also increases the vulnerability of African-American families. Racial discrimination continues to limit Black families' access to housing outside of circumscribed communities. Studies by the U.S. Department of Housing and

Urban Development using Black and White "testers" matched on demographic attributes found that rental housing was more available to Whites, that Whites found it easier to buy a home in 34 percent of the test cases, that Whites received more help in financing their desired homes in 46 percent of the test cases, and that Whites were offered lower rates and better terms on their loans in 17 percent of the test cases (Boston, 1996). In another study, Blacks reported barriers to home ownership at higher rates than Whites (see table 8).

Table 8. Barriers to home ownership

Barrier	Blacks	Whites
Down payment/closing costs	66%	47%
Monthly income	59%	39%
Job security	38%	25%
Credit	37%	21%
Discrimination/social barriers	21%	6%

Source: Boston, K. (1996). *Smart money moves for African Americans.* New York: G. P. Putnam & Sons.

Historical housing discrimination has resulted in the residential segregation of Blacks and Whites. Lower income Black families are particularly vulnerable as a result of this situation. Table 9 shows the residential distribution of low-income, or "poor," Americans by race. Poor Blacks tend to be clustered in the inner cities, whereas poor Whites are evenly distributed in cities, suburbs, and nonmetropolitan areas. Among those poor Whites who live in urban areas, less than one quarter reside in low-income tracts. Thus, there are few White ghettos, whereas 70 percent of poor urban Blacks live in ghettos (Hacker, 1992).

Table 9. Residential distribution of poor Americans by race

Location	Whites	Blacks
Central cities	32.7%	60.3%
Suburbs	35.2%	17.5%
Nonmetropolitan	32.1%	22.2%

Source: Hacker, A. (1992). *Two nations: Black and white, separate, hostile, unequal.* New York: Ballantine.

Higher income Blacks are able to move into wealthier enclaves of Black homes, leaving poor Blacks in the deteriorating inner cities. By contrast, lower income Whites have more housing options and tend to live in more mixed neighborhoods that are not as dilapidated as the neighborhoods in which low-income Blacks reside.

Ghettos are marked by high crime rates, lack of employment opportunities, fewer and poorer city services, dilapidated homes and businesses, and deteriorating social institutions. Therefore, families living in ghettos—the majority of urban poor families who are African American—are at considerable risk for negative outcomes.

As a result of situational risk factors, African Americans tend to face a high degree of stress. The notion of stress implies excessive exposure to environmental forces that can harm a person's well-being. Some social scientists have defined stress as environmental events that make demands on the person, while others have defined stress as the individual's response to events (Fleming, Baum, & Singer, 1984). Stress has also been defined as "any unpleasant and disturbing emotional experience due to frustration." Stress may also result from an alteration or interference with the usual pattern of behavior of families or individuals within families (Theodorson & Theodorson, 1969).

The accumulation of stressors increases an individual's susceptibility to psychological and physical illness including heart disease, cancer, chronic asthma, depression, anxiety, and other mental illnesses (Holmes & Rahe, 1967; Borus & Senay, 1980; Brenner, 1973; Dohrenwend & Dohrenwend, 1981; Gary, 1985; Rabkin & Struening, 1976). The poor health of a family member, especially a primary caretaker or wage earner, places a family at tremendous risk for impaired family functioning.

Traditional Approaches to the Study of African-American Families

Allen (1978) identified three ideological perspectives or value orientations that have been used in the study of Black families. The cultural deviant perspective views Black families as pathological

and dominates the literature. The cultural equivalent approach emerged during the 1970s. It legitimizes African-American families as long as they conform to middle-class family values. The cultural variant perspective views the Black family as a culturally unique, legitimate unit. This approach has been underrepresented in the literature. The protective factor model incorporates a cultural variant perspective, viewing Black families as structures that are in continuous adaptation in an effort to meet the survival and developmental needs of the unit and its members.

Generally, studies of Black families have focused on the impact of historical and contextual factors on the structure of the family. Political and economic conceptual models not normally associated with mainstream family institutions have generally been applied. Staples (1993) argues that this is a result of a general view that Black families are not social institutions but progenitors of social problems such as poverty, crime, and welfare dependency.

The early studies of Frazier and DuBois focused on economic conditions during the rapid urbanization of African Americans in the early part of the 20th century that brought about family disorganization. Moynihan authored the next major study, posing that weaknesses in the Black family were responsible for the deterioration of the Black community. This framework guided much of the work on African-American families during the mid-to-late 1960s. During this period, another group emerged that argued that Black families were much like White families except for the high levels of poverty and history of slavery. African-American families were portrayed as victims rather than criminals. Even so, the unique traits of Black family structure were devalued. Billingsley's work in the late 1960s marked the beginning of the Black nationalist school in which Black families were seen as being nonpathological and having strengths. The problems of the African-American family were viewed largely as a result of neglect by the political and economic systems. Hill enhanced Billingsley's work in the 1970s by systematically defining and examining the strengths of functional African-American families and using quantitative data to support his propositions. The 1980s

were marked by the rise of politically conservative work, most notably that of Wilson (1987) and Jewell (1988). These works revisited the social pathology approach and focused on lower-class Blacks; only this time, the U.S. Government was indicted not for neglect, but for being too forthcoming with benefits for African-American families through entitlement programs and race-specific policies (Staples, 1993).

Two non-deficit-oriented models for studying African-American families that have emerged are the Black feminist model and the Afrocentric model. The Black feminist model, which gained popularity in the 1970s, promotes the goals of racial equality, care and nurturing of children, and strengthening of the Black family system (Joseph & Lewis, 1981, in Staples, 1993). This model is criticized as being limited because as a holistic theoretical framework for understanding Black families, it does not give attention to Black males in families (Staples, 1993).

The Afrocentric model focuses on the comparison of African and African-American cultures. It provides a link to the past and serves as a foundation for the analysis of African-American cultural values and patterns. This model is lauded for its potential to free the study of African-families from references and comparisons to White families. However, it is limited in that it does not concentrate on the effect of this society's political economy in shaping the values and traditions of African-American families (Staples, 1993). Both frameworks are a step in the right direction in terms of drawing on the strengths of Black families. However, it is essential that any theory that seeks to realistically advance the development of the Black family realize the importance of Black males to the family, and to consider the critical importance of political and economic contextual factors that influence family functioning. The protective factor model acknowledges both.

Mainstream Family Research

In contrast to studies of African-American families, mainstream family research since the 1970s has focused on assessing and classifying families and testing family assessment measures and intervention strategies. McCubbin and McCubbin (1992) identify

five major developments in family research that are relevant to social work practice:

1. Continuous testing of the effectiveness of interventions oriented toward family systems.
2. Reemergence of family stress theory and the concomitant identification of critical family processes as targets for intervention, especially the role of social networks, including neighborhoods, family and kinship networks, intergeneration supports, and mutual self-help groups, and the potential support they offer.
3. Advancement of family typologies for classification and intervention.
4. Theory building and research emphasis upon family strengths and capabilities as critical targets for intervention.
5. Development, testing, and refinement of family assessment measures for research, clinical assessment, and program evaluation.

Research on mainstream families can benefit social work with African-American families as well. Of particular relevance to the formulation of the protective factor model are the developments focusing on family stress theory and family strengths and capabilities. Family stress theory is based on the following assumptions set forth by McCubbin and McCubbin (1992):

1. Families face hardships and changes as a natural and predictable aspect of family life over the life cycle.
2. Families develop basic strengths and capabilities designed to foster the growth and development of family members and the family unit and to protect the family from major disruptions in the face of family transitions and changes.
3. Families face crises that force the family to change its traditional mode of functioning and adapt to the situation.
4. Families develop basic and unique strengths and capabilities designed to protect the family from unexpected or nonnormative stressors and strains and to foster the family's adaptation following a family crisis or major transition and change.

5. Families benefit from and contribute to networks of relationships and resources in the community, particularly during periods of stress and crisis.
6. Family functioning is often predictable with patterns of interpersonal behavior that are shaped by environmental factors, intergenerational factors, situational pressures, and normative and nonnormative events.
7. Family functioning can be enhanced through interventions targeting vulnerabilities and dysfunctional patterns, strengths, and capabilities.
8. Families develop and maintain internal resistance and adaptive resources that vary in their strength and resiliency over the family life cycle, but which can be influenced and enhanced to function more effectively.

These assertions provide the basis for understanding the nature of family resilience and resistance to stress. The family stress model has great utility for thinking about the functioning of African-American families in particular, given their greater vulnerability to environmental factors. Thus, the protective factor model borrows the following concepts from the family stress model: stress as a constant in Black families' environment; a focus on influences of the social environment on family functioning; the adaptive capacities of families to manage stress; and a focus on family strengths as the target for intervention/prevention.

The Influence of the Strengths Perspective for Social Work Practice

The protective factor model is also heavily influenced by the strengths perspective in social work. The strengths perspective provides a nondeficit, non-problem-centered framework that makes possible the assessment, affirmation, and further development of the adaptive capacities that African-American families have already developed in response to their unique history. It provides a beginning specification of the mechanisms through which

these strengths operate and suggests techniques by which additional capacities may be developed.

The strengths perspective focuses entirely on enhancing the adaptive capacities of clients, rather than focusing on symptomatology or problem behavior as in the case of traditional social work approaches. Saleebly's (1992) description of the approach focuses on the individual. However, the assumptions and principles are also applicable to families. The strengths perspective is distinguished from other approaches that use clients' strengths in practice such as the life model and the problem-solving approach. The primary focus in these models is problem identification; client strengths are secondary considerations. Thus, traditional models of social work, even those that advocate invoking or using client strengths, are inherently deficit oriented.

Proponents of the strengths perspective cite several disadvantages or limitations to problem-oriented models that are ultimately damaging to the development of a family's adaptive capacities:

- They encourage individualistic rather than socio-environmental solutions and result in a view that people are the cause of their own problems.
- Treatment goals are geared to problem behaviors, thus ensuring a never-ending requirement for continuing intervention.
- They emphasize searching out a problem, which implies that there is an identifiable solution, yet this is often not the case in social work.
- They place the helper in a position of authority and make it difficult for clients to trust their own sense of how to proceed with their lives (Weick et al., 1989).

The strengths perspective posits that there is an inherent power within individuals to create positive change, and that this power that can be an instinctive source of knowledge and healing. This power resides in untapped reservoirs of physical, emotional, cognitive, interpersonal, social, and spiritual resources and competencies. The social environment, no matter how harsh, offers a wealth of personal strengths and resources for the client. Social workers can help clients develop their potential by helping them

become aware of this power and supporting its use in facing challenges. The worker is a collaborator or consultant in this process, but is not the only one in the situation presumed to have relevant, important, or even esoteric knowledge. The focus on client strengths highlights two factors: (1) the impact of the environment on the situation of individuals and families, and (2) the existing adaptive capacities that have allowed the individual to survive despite an oppressive, catastrophic environment (Saleebly, 1992; Schriver, 1995).

Key concepts of this perspective set forth by Saleebly (1992) and Rappaport (1984, in Saleebly, 1992) are described in terms of their significance for understanding protective mechanisms, as follows:

Empowerment involves discovering the inherent power within people. It entails identifying, facilitating, or creating contexts in which people gain influence over decisions that affect their lives. It eschews pejorative labels, paternalism, and the victim mindset in favor of encouraging the development of personal adaptive capacities by trusting in persons' sensibilities and linking them to networks of resources. Community and neighborhood are central features of this perspective, as they provide renewable and expandable sources of strength and resources to individuals.

As a protective mechanism, empowerment means that families can develop the sense of competence and efficacy, and access the resources required to negotiate or manage risk situations effectively.

Membership refers to a sense of belonging to a network of supportive individuals or groups in which strengths can be respected and nurtured. It entails the notion of social support whereby families can receive affective support such as caring, fellowship, and love and affection, as well as instrumental support such as money, goods, and services. In addition to being able to receive support, families that have membership in such networks must also *give* support to others in the network. This requirement engenders feelings of self-worth and esteem as individuals recognize that they have something to offer and are valued by others.

Regeneration refers to the self-healing powers that individuals and families inherently possess. Communities and neighborhoods

are also viewed as generative, possessing powers of transformation that may be unknown to social institutions or public policies. Regeneration includes the use of spiritual and psychic energy and the infinite powers of the mind to interpret and reframe events in ways that are manageable for individuals and families. Among African Americans in particular, regeneration may be fueled by religious conviction or faith, as well as by the common history of overcoming oppressive circumstances.

Synergy is the process by which phenomena are interrelated to create new patterns and resources that exceed the complexity of their individual constituents. It is the dynamic, the engine, that drives the processes involved in empowerment, membership, and regeneration. This concept is consistent with African-American culture, which tends to be collective or group oriented in nature.

Dialog and collaboration are interactive processes through which people come to know and test their internal strengths and powers. These, like synergy, are better understood as the mechanics of the strengths approach. Whereas synergy is the force behind the strengths perspective, dialog and collaboration are instruments or tools of the approach. Honest, humble, empathic dialog is important in affirming humanity and dignity, and in achieving "horizontal relationships." Collaboration characterizes the relationships between families and other systems in their social environments, including those with social workers.

Suspension of disbelief refers to the social worker's disposition in working with a family. However, it is also important in other interactions within the family and between a family and systems in its social environment. This concept essentially involves affirming persons by accepting their view of reality or truth as a starting point in the process of dialog and collaboration. It is acknowledged that people may misrepresent themselves in the interest of self-protection. However, telling the truth may also be influenced by the manner in which the truth is sought, by sociocultural variables that impinge on the situation, and by a person's subjective perception of reality.

The strengths perspective provides a foundation for an understanding of the mechanisms by which protective factors operate. In order to identify specific protective factors for

African-American families, it is necessary to examine previous research on Black family strengths.

Research on the Strengths of African-American Families

Despite the defect orientation that has typified research on African-American families, scholars have identified several strengths of these families. Billingsley (1968) and Hill (1972) are the forerunners in emphasizing family strengths in the analysis of Black families. In this regard, Billingsley (1968) used the construct "opportunity screens" as the key to the survival and stability of strong Black families. These opportunity screens or attributes included (1) a set of family values, (2) religious conviction and behavior, (3) educational aspirations and achievement, (4) economic security and property ownership, (5) kinship bonds or ties, and (6) community involvement. Analyzing and interpreting census data, Hill was able to identify five strengths found in African-American families: (1) a strong kinship bond, (2) a strong work orientation, (3) an adaptability of family roles, (4) a strong achievement orientation, and (5) a strong religious orientation.

Other family researchers have documented empirically that the family strengths identified by Hill and Billingsley are indeed present in many Black families (Gary, 1989; Christopherson, 1977; Lewis & Looney, 1983; Martin & Martin, 1978; McAdoo, 1978; Royce & Turner, 1980; Stack, 1974). Based on these investigations, strengths emerged in the following domains:

- Work (stable employment, property ownership, and a strong work orientation).
- Education (high educational aspirations, expectations, and attainment).
- Family (role flexibility, shared responsibility, a strong kinship bond involving a high degree of commitment and mutual obligations).
- Coping capabilities (an ability to deal with crises in a positive manner, helping networks, and exchanges).
- Affective support (love, an ability to affirm, respect, and appreciate each other).

Although the existence of Black family strengths has been documented, there are limitations to their function as protective factors. First, these strengths exist in varying degrees of intensity and duration in families. Moreover, a number of factors are likely to affect the existence of these strengths, including (1) the age of the family head, (2) the type of family structure, (3) marital history and behavior of spouses, (4) socioeconomic status, (5) characteristics of the spouses' families of origin, (6) family size, (7) social transactions (formal and informal) of the family, and (8) psychological attributes of family members.

A Study of Protective Factors in African-American Families

Drawing on previous research on Black families, Gary (1989) used an ethnographic methodology to identify attributes that serve as protective factors. The study was designed to address some of the limitations of previous Black family research such as (1) the need to examine the behavior of strong Black families rather than unhealthy ones, (2) the need for ideographic research on men as well as women in family studies, (3) the need to focus on how Black families solve problems rather than a singular focus on the extent of the problems that exist, (4) the need for data from noninstitutional sources to inform the development of programs to assist Black families, and (5) the need for a sociocultural frame of reference to study how families differ within the context of the Black community rather than interracial comparisons between Black families and others.

A sample of 50 families living in Washington, DC, participated in the study. Twenty-six of the families were dual parent, and 24 were headed by single females. All families were required to have been together for at least 5 years and to have a minor child in the home. Families were nominated by community groups based upon their perceived strength and stability.

In-depth individual interviews were held with each parent. Staff members and other experienced interviewers administered the questionnaire. Interviews averaged 2 to 3 hours in length.

Detailed data analysis revealed several protective mechanisms operating among strong, stable African-American families. These can be broadly classified as internal and external factors. Internal factors included the following:

- *A high degree of religious or spiritual orientation* (as evidenced by church membership, church attendance, a sense of right and wrong, teaching moral values, and a shared religious core).
- *A sense of racial pride* (telling their children about Black history, discussing racism in one's family, telling children what it is like to be African-American, preference for being identified as an African-American).
- *A strong achievement orientation* (high expectations for achievement and attainment, goal directedness, etc.).
- *Resourcefulness* (possessing personal talents and skills, self-reliance, self-sufficiency, independence, and the ability to cope with crises).
- *Family unity* (possessing a sense of cohesiveness, family pride, family togetherness, and commitment, i.e., the family comes first).
- *Display of love and acceptance* (the ability to affirm one another and to respect, appreciate, and trust each other).
- *A strong economic foundation* (a relatively high or stable family income, employment, home ownership, and a strong work orientation).
- *An adaptability of family roles* (that is, having role flexibility, sharing responsibility, and communicating with each other).

External factors identified included the following:

- *A strong kinship bond* (for example, a high degree of commitment to the family, a feeling of mutual obligation, kin interaction, and support).
- *Community involvement* (service to others, and membership and active involvement in community organizations).

The strengths perspective is useful in understanding how these protective factors might work. Most of these factors seem to serve as regenerative sources for individuals and families.

Regenerativity may be derived from intrapersonal, intrafamilial, or intergroup sources. In this sense, the protective factors seem particularly beneficial in assisting families and individual members to frame risk situations in ways that are manageable, and in providing psychological, material, and other types of resources to overcome risk situations.

For example, religiosity may lead families to feel that risky situations are tests of their faith in God. While the situations may still cause stress, the belief that God would not present them with challenges they could not overcome may keep the family from becoming overwhelmed. Similarly, racial pride may enable families to deal with stressful situations by invoking knowledge of other Blacks who have overcome similar or worse situations or by engendering an overall feeling of strength as a member of a race that has survived despite tremendous violence and oppression.

Family love and acceptance and family unity provide important psychological protection by creating a safe haven for retreat in times of difficulty. The unconditional positive regard of the primary group can afford individuals protection from the assaults on their self-worth and esteem waged by harsh environments.

Resourcefulness, a strong economic base, and social support provide material aids for managing risk. For example, having savings or alternative sources of income can buffer the impact of job loss of a primary wage earner in the family. Access to cash or in-kind services from relatives and acquaintances are protective in the case of legal difficulties, unexpected pregnancy, or acute illness on the part of a family member.

This list of factors is by no means exhaustive, but it suggests the types of protective factors that exist and the domains into which they fall. Hence, these factors provide a foundation for a typology of protective factors for African-American families that could guide development and assessment of prevention plans for specific Black families based upon their idiosyncratic characteristics.

Conclusion

Given the general vulnerability of Black families in this society across socioeconomic levels, a prevention-oriented model of social work practice is indicated. A model focusing on identifying and enhancing adaptive capacities for managing stress is most promising, given the high duration and frequency of stressors that African-American families face. Thus, a protective factor model is recommended. This model focuses on identifying and developing strengths that enable families to effectively manage risk without damaging family functioning and stability.

The protective factor model is based on the assumptions of the family stress model, which asserts that families develop coping capacities and/or then adapt their form and function to manage environmental and other stressors that are related to the family life cycle. In addition, the model uses concepts from the strengths perspective in social work practice to provide a beginning understanding of how protective factors mediate risk.

Several characteristics that are common to strong, stable Black families have been identified and provide a basis for the development of a typology of protective factors. This typology might be organized using an ecological perspective; that is, protective factors may be classified in terms of family factors, neighborhood and community factors, and societal factors. Alternatively, protective factors may be classified as sociocultural, demographic, and stress related.

Additional research is needed to identify other protective mechanisms and to examine the relationships between demographics and protective factors to get a better understanding of how the broader context of resilience (i.e., the accumulation or combination of protective factors that provide family stability in risk situations) is achieved.

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5

The More Things Change, the More They Stay the Same: A Framework for Effective Practice With African Americans

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Every man has two educations: that which is given to him, and the other which he gives himself .What we are merely taught seldom nourishes the mind like that which we teach ourselves.

—*Carter G. Woodson, 1977, "The Miseducation of the Negro"*

Introduction

Many older Black folks have used the statement "The more things change, the more they stay the same" over the years to describe the state of the art of social conditions. We have chosen to use this old saying because it evokes respect for the worldview of many African Americans. Many have gone before us, and many have paved the road for all that is good and effective. This chapter presents a new way of using theoretical and practice information when working with African Americans in substance abuse prevention and treatment settings.

Effective professional interaction with individuals from the African diaspora has been studied, examined, researched, and discussed by many African-American social scientists and practitioners (Billingsley, 1968, 1990; Brisbane & Womble, 1992; Davis & Proctor, 1989; Hill, 1972; Nobles, 1985; Pinderhughes, 1989; Boyd-Franklin, 1989). Therefore, when addressing effective practice with African Americans, a new practice model is not required. What is necessary, however, is a framework that will allow practitioners to use existing models of practice more effectively in their interventions with African Americans.

Throughout this chapter, the term "African American" is used to describe the combined heritage of Black persons living in the Americas whose ancestral heritage is African. This includes persons who were either born in or have their permanent residency in countries of the Caribbean, Africa, and North and South America. The term "African American" is inclusive of all African people across the diaspora. The terms "African Americans" and "Blacks" are used synonymously throughout this chapter. It is also important to note that the authors view *practice* as an encompassing term to include the knowledge and skills a practitioner needs to intervene at the individual and community levels.

In the field of substance abuse, professionals have grappled with the problem of providing prevention and treatment services to culturally diverse populations. Many programs provide clinical services to African-American clients with no regard to issues of culture, race, or ethnicity (Brisbane & Womble, 1985a, 1992). This omission can be very detrimental to both the African-American client and the treatment agency, as it negatively impacts service utilization and provision.

Ethnically competent practice with individuals from racial/ethnic groups should involve a multicultural perspective that attends to the cultural values and sociocultural reality of the group (Chau, 1991). Health and human service professionals are constantly challenged to deliver more effective services to ethnic groups including African Americans. There has also been an ongoing debate about the clinical relevance of issues such as ethnicity, social class, ethnic group membership, therapist-patient match, and culturally relevant treatment (Chau, 1991; Comas-Diaz, 1988;

Boyd-Franklin, 1989). This debate will probably continue; however, the ever-present and pressing issue is the delivery of effective intervention services to African-American individuals who are chemically dependent. This chapter represents one effort to stimulate the thinking and practice of professionals in the area of substance abuse. It is our hope that the content can be used to develop practitioners who are more effective in all of their practice interventions with diverse populations of African Americans.

The remainder of this chapter includes an overview of some theoretical and practice models that reflect the cultural dynamics involved in the helping process, a presentation of a framework that practitioners can apply to the culturally sensitive practice models, and suggestions for implementing and evaluating the effectiveness of prevention programs.

African-Centered Perspective

It is essential to use an African-American cultural framework in evaluating African-American clients. The traditional, Eurocentric framework often results in an inappropriate, inaccurate, or negative evaluation of African-American clients. The Afrocentric framework tends to clarify the functionality of certain behaviors of the African-American client. It also delineates and explicates some differences in culture, worldview, and historical experiences between African Americans and European Americans (Jones, 1985). Afrocentric refers to a worldview centered in Africa as the historical point of generation (Meyers, 1988).

Nobles (1985) uses Afrocentricity as a theoretical model for viewing the Black family. Afrocentricity is "the intellectual and philosophical foundation used to develop the political, scientific and moral criterion for authenticating the reality of African family processes. It is the utilization of the African experience as the core paradigm for human liberation and higher level human functioning" (Nobles & Goddard, 1984, p. 127). "A primary concern for this discussion is ultimately to offer a theoretical framework to critique the literature on the Black family that therefore will provide us with a systematic way to refute theoretically and empirically the erroneous and destructive conceptualizations of Black

family life found in the literature to suggest the initial guidelines for guaranteeing an accurate and authentic characterization of the Black family" (Nobles, 1986, pp. 3–4).

Nobles argues that it is necessary for those who engage in scientific inquiry of Afrocentricity to have the "capacity to understand" the psychoculture of the group. The preference is for one to be an insider of that culture, although Nobles argues that one's status as an insider does not guarantee an understanding of the phenomena. As a result of racial and cultural oppression, many African Americans—especially in the academic arena—have been forced to examine the world through White lenses. This situation suggests why some previous Black social scientists had not determined an analysis and discussion of the Black family significantly different from that of White researchers (Nobles, 1985). Nobles further states:

> The real consequence of investigation of Black people being incarcerated in the worldview of White Americans has been that our scientific understanding of Black social reality, particularly Black family life, has been for the most part determined by the indices and frame of reference (i.e., racism, white supremacy, and exploitation) of the worldview of the traditional White social scientist (Nobles, 1985, p. 70).

Therefore, it is an African worldview that is at the base of the Black cultural sphere. Consequently, the study of research on Black family life must take as its theoretical model the African philosophical world view as reflected in contemporary Black family life. "A theoretical and empirical framework for defining Black social reality must, therefore, be based on African cultural residuals as reflected in the world view, normative assumptions and frame of reference of Black people" (Nobles, 1985). Nobles challenges African-American scholars to rethink our method and approach when studying and working with African-American families. Although Nobles' perspective and approach may be considered radical by some, it bears introduction as an alternative view.

This review of an African-centered perspective is vital because the culture and heritage of the individual is critical to discussions

about the individual. The African-centered perspective operates from a premise that individuals are deeply affected by their racial/ethnic identities and that their identities impact their functioning.

Community and Environment Perspective

Black mental health professionals have seriously questioned the applicability of traditional models of mental health practice to individuals in the Black community. Individual functioning should be viewed within the context of the social, political, economic, and other institutional forces with which the individual must cope (Gary & Jones, 1978). When working with African Americans, the clinician must be aware of the community where clients live versus the community where those clients work or attend school. Often, African-American communities are viewed as monolithic, usually poor, inner-city communities with all attendant social ills. However, it is important to emphasize that there is no single, prototypical African-American community—they are as diverse as the peoples who comprise them.

When developing a prevention and treatment model for African Americans, it is important to explore the theory of dual perspective or cultural duality. One must recognize the duality or "double-consciousness" contained in the Black-American culture (Jaynes and Williams, 1989; Jacobs & Bowles, 1988; Chestang, 1972). Gary (1978) developed a practice and research model for the Black community that is based on the systems theory approach. His model examines the Black individual in constant interaction with dual interrelated subsystems—biopsychological or internal, and sociocultural or external.

Chestang (1972) presents this dual perspective as a concept to explain how people incorporate personal interaction and their environment. His major premise is that social work needs a view and an approach that takes environmental effects into consideration when determining the character development of Black persons. It is a conceptual model for understanding Black character

structure as it develops in a hostile environment. The dual perspective incorporates the theoretical practice framework of social systems and ecological perspectives. Chestang also identifies some concepts as being embodied in the formulations reflected in existing psychosocial and sociocultural theory (Chestang, 1976).

Norton (1993) suggests that social workers should use the dual perspective to focus on differences and apply it within the context of an anthropological-ecological approach to emphasize the universal goals of societal organization that underlie human behavior: "The dual perspective posits that all people are embedded in at least two interrelated social systems. The first is the immediate socioeconomic, cultural, or racial environment represented by their family and community (the nurturing system of Chestang, 1972). The second is described as the economic, political and educational systems of the wider society, i.e., the general social and political macrosystem" (Norton, 1993, p. 85).

Anyone working in substance abuse prevention or treatment must be aware of the range of diversity among African-American persons and the communities in which they live. Some communities show obvious signs of illicit, rampant drug use, with alcohol and drug abusers and dealers on street corners, and liquor stores and liquor-serving establishments in residential settings near schools and churches. Other communities may have more subdued, hidden problems such as closet drinking and drug use, happy hours, domestic violence, or child neglect and abuse. Practice and experience should tell us that even though the signs of the problem may be displayed differently, the need for intervention may be equally pervasive.

Building on the dual perspective, Beverly (1989) and Bell and Evans (1981) developed the concept of dual and double consciousness. Beverly suggests that dual consciousness is closely tied to the concept of empowerment. He believes it is possible to have a process that can equip Black alcoholic clients with the knowledge and skills necessary to transcend their chemical dependency through "culturally sensitive and sociohistorically relevant clinical intervention techniques" (Beverly, 1989, p. 374). One such technique that he describes is the use of dual consciousness.

Bell and Evans (1981) also address the concept of Black double consciousness in alcoholism counseling. They state, "It is important to help Black alcoholic clients understand themselves in terms of dualities of: (a) how they see themselves as a Black people, and (b) how they see Whites." That double-consciousness model is sometimes perceived as "successful schizophrenia," existing in two worlds, one Black and one White. The stress, pain, and negative self-perceptions that this duality causes must be explored by the counselors seeking to help Black clients successfully achieve sobriety (p. 30). These authors further suggest that it is essential to understand the racial issues that cause inner stress. This idea leads to the following discussion of the literature that addresses the significance of race and racism on treatment.

Race and Racism Perspective

Personal and institutional racism are seen as key variables related to stressful events in the lives of Black people (Gary, 1978). Research suggests that the impact of racism and race on a client's life should be assessed and addressed at the initial phase of treatment (Robinson, 1989; Brisbane & Womble, 1992). Robinson (1989) presented a model for assessment that enables the clinician to identify and address racially and ethnically based impediments to treatment. The model's four components are (1) racial congruence of the client, (2) influence of race on the present problem, (3) the clinician's racial awareness, and (4) the clinician's strategies. These issues could also be impediments to prevention efforts with African Americans. It is important for clients to know that racist acts, whether they are perceived or factual, are treatment issues (Brisbane and Womble, 1992). These issues should be addressed with the clients by their counselors, therapists, or other appropriate persons.

Davis and Proctor (1989) also recognize the impact of race on the treatment process:

Research findings from the social sciences indicate that perception of another person's race, gender, or socioeconomic status often triggers assumptions and expectations about the other's

attitudes, beliefs, competence, and behaviors. Whether these assumptions are correct or incorrect, they have implications for the helping relationship .[Ethnically] similar individuals are likely to assume that they view the world in a similar manner, and hence conclude that the other's reading of reality is valid and that his or her advice can be trusted (p. viii).

Effective prevention and treatment interventions and programs demand that those providing the services understand and be sensitive to the values, culture, and special needs of all groups served, especially ethnic and racial groups (Jacobs & Bowles, 1988). Gary and Berry (1985) conducted an empirical study that explored how demographic factors, sociocultural patterns, and racial consciousness predict the attitudes of Black adults toward substance abuse. One of their findings was that respondents who were very conscious of racial issues were likely to be less tolerant of substance abuse than those who scored low on racial consciousness. This information may be relevant for substance abuse prevention work with African-American youths and adults.

Nancy Boyd-Franklin's book "Black Families in Therapy" (1989) highlights many aspects of the diversity of Black families that are often overlooked and misunderstood. One major premise of the book is that the African-American culture represents a distinct ethnic and racial experience. This experience is unique because of Blacks' history; African legacy; and the experience of slavery, racism, discrimination, and victimization.

It is also critical that African-American practitioners understand their own ethnicity and how it may influence their practice. Some questions they may want to explore as they strive for self-awareness include the following: (1) Are we all really the same, even though we may have the same history? (2) How different or similar have our life experiences been in relation to family, education, employment, church/spiritual experiences? (3) Does social class make a difference? (4) Will social class make a difference in our expectations of each other? (Devore, 1992).

Devore (1992) raises some issues that White practitioners may want to answer as they work with African Americans. These issues include (1) examining how White groups or families related

to African Americans historically, (2) exploring the family/community message about the value or worthlessness of African Americans, (3) acknowledging whether they believed that message then or now, and (4) identifying the similarities and differences between their community and the African-American community they practice in or that their clients come from. Exploring these issues will help bridge the gap between the diversity of same-race and different-race practitioners.

African-American Family Strengths Perspective

Several authors stress how important it is to focus on and assess the client's strengths as a basic treatment strategy (Pinderhughes, 1989; Solomon, 1976; Brisbane & Womble, 1992). Hill's classic book "The Strengths of Black Families" (1972) stresses the importance for scholars and researchers to emphasize the strengths of Black families instead of the usual preoccupation with pathology and the "blaming the victim" perspective that many researchers have used. It is important to assess the client's strengths in the engagement-assessment process. To incorporate clients' strengths, one must identify their potential capacity and recognize opportunities available in their social and physical environment (Solomon, 1976).

Recognition of clients' strengths is especially important in treatment of substance abuse among African Americans. It is so significant that treatment should always begin with acknowledgment of the client's strengths. Of course, the first strength to acknowledge is the client's presence and willingness to participate in the prevention or treatment program (Dozier, 1994).

Brisbane and Womble (1992) identify a psychosocial cultural assessment that focuses specifically on cultural strengths, race issues, and stereotypes. These characteristics may impede treatment if they are not addressed initially. Many clients bring issues of race into treatment, but they are uncomfortable exploring them with their therapist. When practitioners identify and build on the existing strengths of the client, they become more in touch with

the client's current level of functioning and current sources of individual and personal power (Gutierrez, 1990; Pinderhughes, 1989; Solomon, 1976). Building on strengths is one additional way practitioners can identify and deal with the impact of race and cultural diversity in the helping encounter. This technique can be an asset because clients who feel that the practitioner sees some good in them will more likely be open to sharing intimate personal fears and frustrations, which will facilitate a more productive therapeutic relationship.

As an illustration of the strengths perspective, it is important to recognize the Black female's survival role in Black alcoholic families when assessing her strengths. This role is significantly related to racial and cultural factors (Brisbane & Womble, 1992). When the mother in a Black family has an alcohol problem, other females in the family assume the parenting role. This role adaptation illustrates Hill's (1972) findings that "adaptability of family roles" is a strength. Rather than disown or deny the acceptance of parental responsibility of the alcoholic mother, the Black family adapts and develops the function of her role with other females in the family.

Strong religious orientation is one of the five strengths identified by Hill (1972). This encompasses spirituality, which is a very important cultural trait that should be addressed when providing prevention and treatment services to African Americans dependent on drugs. The assessment should include a series of questions that address the client's spirituality, belief system, and/or religion. During assessment, a client's sources of hope and strength should be identified. This identification will often lead to discussions regarding the client's concept of God and spirituality (Knox, 1985). The three sources of hope and strength that Knox (1985) identifies are (1) the family as a source of support, (2) faith in God for help in the removal of psychological stresses, and (3) the church as an emotional release of the tensions faced in an oppressive society (p. 35). These three sources are the basis of the strong religious and spiritual orientation that has accounted for much of the survival of the Black family. In prevention and treatment settings, these issues must be explored and incorporated.

Issues of Power

Any discussion about practice with African Americans must include some reference to the significance of power in the helping relationship. Prevention and treatment workers must deal with issues of powerlessness, as these issues relate to their ability to effect change in other aspects of their client's lives. Solomon (1976) defines powerlessness as "the inability to manage emotions, skills, knowledge or material resources in a way that effective performance of valued social roles will lead to personal gratification" (p. 16). The power deficiency so often seen within African-American communities stems from a complex and dynamic interrelationship between the person and a hostile social environment. There is often a direct relationship between powerlessness felt by a client and powerlessness experienced by the prevention and treatment worker. There is also often a direct relationship between the power assigned to a worker and the powerlessness felt by the client. Clients who enter treatment may assign power to the practitioner because the practitioner is seen as the one who can remove all problems and actually eliminate the dependency. These dynamics of power must be addressed in the therapeutic setting.

The issues of trust and mistrust, which are so crucial in forming treatment relationships with African Americans, often cause prevention and treatment workers to disclose their powerlessness to clients so as not to mislead them. African-American workers, in bureaucratic settings that are often racist in practice, are quite aware of their limitations for effecting change within the system. The power base of the clinician reflects the levels of ability both to accept responsibility for self and society, as well as to understand the limitations and obligations of power and authority (Robinson, 1989). All these issues are important when developing culturally based prevention and treatment programs for African Americans.

From the discussion presented thus far, we see that there is theoretical knowledge about African Americans that has been adequately incorporated into different approaches to practice. The challenge remains to take the knowledge and experiences that have been developed, expand them, and increase their effectiveness.

Although the theoretical perspectives and practice approaches presented have been used effectively with some populations of African Americans, we feel that there are some limitations in universally applying these approaches to all African Americans. Some limitations are present simply because the practice models and the theoretical perspectives have been developed within the context and frame of traditional education and practice. The next section of this chapter will discuss the limitations of the traditional approach to education and practice, and will provide an alternative framework that should allow for the effective application of the practice approaches and theoretical perspectives presented thus far.

Traditional Practice

Traditional models of practice are based on a Eurocentric epistemology that is not necessarily complementary to the cultural experiences and worldview of African Americans. Most models of practice have emerged from the traditional epistemology of practice that is learned in higher education (Schon, 1983). Schon and others, particularly authors who support the development of critical thinking, suggest that the traditional ways of doing practice must change if practitioners want to be effective in their helping roles (Schon, 1983, 1987; Brookfield, 1987; Jackson-White, 1992).

Research and practice have documented that the cultural lens of African Americans is different from the cultural lens of Europeans (Nobles, 1985; Meyers, 1988). As such, we contend that African Americans have adapted much of their learning and approaches to practice using the traditional epistemology of higher education (Hale-Benson, 1986; Jackson-White, 1987). Practitioners who work with individuals from African-American communities will be better equipped to provide effective interventions if they can incorporate the ability to *reflect in action* into their repertoire of skills.

Until recently, the failure of different practice interventions was viewed as a failure of the client to respond to treatment. The failure of the treatment intervention resulted not only in additional blame and responsibility placed on clients of African an-

cestry, it also created a perception that African Americans as a group could in fact not be helped because they could not engage successfully in the therapeutic encounter.

This "blame response" is particularly important as we examine the multitude of problems that substance abuse presents in African-American communities. Substance abuse has played a significant role in destabilizing, disrupting, and dissolving Black families. The deteriorating and diminishing Black family has been negatively influenced by the escalating availability of inexpensive drugs (i.e., alcohol, marijuana, crack cocaine). This is especially true in urban areas and is related to a continuing value of use of alcohol for social or conviviality purposes and for psychological coping (Harper, 1991). According to Nobles and Goddard (1989), the prevalence of drugs in the Black community, with concomitant violence, has served to reduce the quantity and quality of Black life. The quantity of life in the African-American community is directly affected because "drug use is a primary contributory factor to the lower life expectancy of the African-American population.… Given the violence, unpredictability, and volatile nature of drug trafficking and drug-related behavior, we can estimate that 80 percent of the 'excess deaths' due to homicide are drug-related" (p. 176).

Because the substance abuse problem persists and continues to grow, the stage is set for the placing of additional blame on the African-American community for failure to remedy the problem. It is, therefore, appropriate and timely to examine ways to expand the cultural efficacy of the different prevention and treatment models. We are not challenging the content of the practice models that have been developed. Rather, we will present a framework that will enhance the application of those practice models that are culturally based but practiced in the prescriptive methods of logical positivism.

Alternative Models

Schon (1983) presents a model of reflective practice that allows the practitioner to incorporate theoretical knowledge, experience, and intuition in the development of practice skills. This model of

reflective practice suggests that the practitioner can never learn all there is to know about all practice situations. What practitioners can learn, however, is a body of knowledge, a host of skills, and the ability to reflect on each practice situation. If practitioners can develop the art of reflection, they should be better equipped to develop a unique practice intervention for the unique qualities any client may bring to the helping encounter. *Reflection in action* is the process; *reflective practice* is the application of that process.

The process of reflecting in action requires practitioners to "*discover* the meaning of interpersonal situations in a new way, *invent* new strategies of action, and *produce* and *evaluate* the strategies they had invented" (Schon, 1987, p. 269). This process of discovering, inventing, producing, and evaluating requires the practitioner to draw upon theoretical knowledge. The practitioner must give some deliberate thought to the meaning of each particular situation. This deliberation is critical to the reflection-in-action process. It is critical because at this juncture, the practitioner must (1) identify assumptions being made about the client, (2) open dialogue to seek clarification of these assumptions from the client's perspective, and (3) make an informed judgment about the next steps using client information, theoretical knowledge, intuition, and previous experience. This process of *reflection in action* does not require an approach based on a specific practice model. It thus frees the practitioner to determine the best intervention based upon theoretical knowledge, practice experience, and client information.

Strengths of Reflective Practice With African Americans

Clearly, the most compelling strength of the reflective process is that it does not assume a prescriptive approach to practice. Prescriptive practice gives the practitioner an unequal edge over the client. Because the practitioner is viewed as the one who has an answer and can help clients solve their problem, the practitioner automatically is placed in a position of power. The dynamic of power in the helping relationship very often is the factor that excludes clients from assuming responsibility for their problem and

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its solution. This is particularly evident when the client is African American. More often than not, clients' substance abuse problems make them vulnerable when they enter a helping situation. This vulnerability automatically creates an unequal distribution of power. One would have to question the efficacy of any intervention that does not consider these factors as critical to problem definition, resolution, prevention, and evaluation.

The process of reflection in action gives practitioners who come in contact with clients from African-American communities the skills necessary to proceed with a productive helping encounter. Reflection in action removes control from the practitioner. It provides the practitioner with a set of deliberate skills that will focus deliberation, use knowledge, and build on sensitivity to cultural variations. Chau (1991) summarizes this idea as follows:

> *Human and cultural diversity have a significant impact on the practice of interpersonal helping and delivery of services. A key concept is that maximum utilization and effective services occur when there is a "goodness of fit" between the services and the sociocultural reality of the individuals or groups being served (p. 23).*

The critical source of knowledge, then, becomes the quality and depth of factual knowledge the practitioner has about the diversity of African Americans who are present for treatment. This diversity may include persons born in the United States or those born in the Caribbean, Canada, South America, or on the continent of Africa. Whether clients are native born, first generation, or subsequent generation is critical to understanding their view of their culture and their view of the problem. Regional differences cause another level of diversity: being born in the South versus the North, Midwest versus Southwest, or in a rural area versus an urban or suburban area. The impact of social class as perceived by the client and the client's family and community system is also a variable in understanding client diversity. If practitioners have a solid and clear understanding of the components and the range of diversity of African-American cultures, then they are better equipped to apply the reflective process.

Reflective Practice and Prevention

The application of the reflective process to prevention and evaluation of substance abuse treatment programs would follow the same process as reflection in action with individual clients. Practitioners engaged in developing prevention programs would need to adapt the needs assessment process to include the reality of the problem as viewed by the population that is affected. This problem definition is critical in prevention programs. One has only to examine prevention efforts that have been undertaken and failed.

The diversity of the culture within the African-American community makes marketing of prevention strategies somewhat difficult. What might work in one region, city, or town may not work in another. The implementation of intrapersonal and interpersonal prevention efforts may be particularly difficult for individuals of any ethnicity or race who lack contact with or who are insensitive to and ignorant of the culture of the targeted population. Prevention efforts need to be sensitive to the diversity of the African-American community and be directed toward incorporating the experiences, relationships, activities, and institutions central to the everyday lives of the people in that community.

When designing substance abuse prevention programs targeted to African Americans, one needs to be aware that there are also differences in the interpretation of substance abuse problems. Prevention practitioners using reflective methods would first have to determine how the problem is viewed in the community. The presence of drugs and alcohol in African-American communities is defined problematically from many different perspectives. In one community, for instance, the consumption of alcohol may not be viewed as a problem, although significant numbers of people might rely upon alcohol to make it through the day, night, or weekend. To develop an effective prevention program, the reflective practitioner would engage community residents in a dialogue to facilitate a framing and reframing of the problem. Theoretical knowledge about the causes and consequences of alcohol abuse, coupled with the practitioner's openness to hearing the definition of the problem as viewed by the clients, paves the way for

developing prevention programs that are aimed at problems as defined by the community.

The practitioner must then work with the community to develop, discover, or invent the appropriate strategies for implementing the program. The point to emphasize is that the practitioner does not exercise unilateral control of the situation, but uses theory, experience, and most important, input from clients to develop an appropriate program. The practitioner frames the problem as defined by the community (i.e., the client); the strategies for preventing the problem build from the process of reflection within the specific community and for the specific client group. The reflective practitioner would not expect to have the same problem definition nor the same strategies when initiating a prevention program with another community of African Americans—therein lies the strength of this framework for practice with African Americans. It requires knowledge; it requires the inclusion of the client; and it recognizes that each situation is unique. As such, no assumptions or generalizations can be made about the client, the problem, or the method used to achieve the best solution.

Reflective Practice and Evaluation

Evaluation of social programs always presents the evaluator with the challenge of defining the agenda for the evaluation. This definition of agenda becomes even more sensitive when the evaluation is of an alcohol and drug program in communities of racial and ethnic diversity (Orlandi, 1992b).

The challenge for evaluators of substance abuse programs in African-American communities is to be able to clearly articulate the answers to the *who* and the *why* questions (Orlandi, 1992a). In his discussion about evaluation of substance abuse programs in ethnic and racial communities, Orlandi suggests that "even more potentially troublesome, however, are the pitfalls inherent in trying to determine *who* is involved in the evaluation and *why* the evaluation is being conducted in the first place" (Orlandi, 1992b, p. 15). If you understand the sociopolitical consequences of racism and discrimination and you understand the "healthy para-

noia" of African Americans (as described by Grier & Cobbs, 1968), it becomes increasingly clear why the evaluation agenda of substance abuse programs in African-American communities must be handled with clarity and competence. The concept of healthy paranoia means that African Americans should have some degree of suspicion in a society that has discriminated and oppressed them (Grier & Cobbs, 1968). This concept is most appropriate when evaluating substance abuse programs in African-American communities.

Orlandi (1992) continues by suggesting a linkage approach to evaluating program planning and implementation. This approach would require evaluators to possess not only expertise in evaluation, but also in cultural competence. He concludes his discussion with questions and a process that shares similarities with the approach to evaluation that a reflective practitioner might use.

Using the process of reflection in action, the practitioner engaged in a program evaluation would begin by determining the answer to the *why* question. Because the processes of reflection in action require continuous dialogue with all relevant parties, the *why* of the evaluation would eventually have to surface and be stated clearly. It is difficult to maintain hidden agendas with the process of reflection because it requires constant dialogue in order to frame and reframe the problem. The *why* question is also critical. It sets the stage for determining who is involved with the evaluations. The practitioner who uses reflection in action has to contact and establish dialogue with all the pertinent actors.

The reflective practitioner who conducts evaluations of programs in African-American communities would also need to be knowledgeable about the culture of the particular community program being evaluated. As in prevention programming, this is the strength of reflective practice. The practitioner approaches each situation as unique and draws upon theoretical knowledge, experiences, intuition, and practice expertise to frame the problem and the solutions. Combining this approach with the unique cultural experiences of the population builds an evaluation process that is culturally sensitive and programmatically relevant.

Conclusion

An overview has been presented of several theoretical and practice perspectives to consider when entering a professional intervention encounter with persons from the diverse African-American populations. A practice model has also been presented that should allow practitioners the flexibility to incorporate practice material with the requisite cultural content needed for every intervention with African Americans.

African Americans have never been a monolithic group. Fortunately, practitioners and others are beginning to realize that diversity exists within the African-American community. The diversity represents a richness of variations. We hope that the content of this chapter encourages practitioners to recognize and respect the variations, and to develop new knowledge and skills. Often, the additional learning that we acquire becomes the most meaningful in developing our true professional selves.

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6
Culturally Based Health Promotion: Practices and Systems

Ronald L. Braithwaite, Ph.D.

Introduction

This chapter explores the parameters of practices and systems in culturally based health promotion, with a particular focus on the application of these practices and systems to African-American communities in the United States. Emphasis is on various barriers to and supports for culturally sensitive health interventions. In addition, lessons learned from applications in the Third World, as well as those from a community-oriented primary care model implemented here in the United States, will be discussed. These community health systems have been successful in addressing culturally based health promotion goals. The use of ethnographic methods as a precursor to full-scale design and implementation of community-based health promotion interventions is also covered.

The context that serves as the impetus for this chapter raises three pertinent questions. First, why and for whom is cultural sensitivity an important issue? Second, what have been the barriers to incorporating culturally sensitive concepts and practices in the health promotion movement? And third, why are culturally sensitive interventions important to the achievement of the U.S. Public Health Service's "Healthy People 2000" objectives?

The Importance of Cultural Sensitivity

Historically and up to the present day, reports of mortality and morbidity continue to document the disparities between ethnic/racial populations and majority citizens (Braithwaite & Taylor, 1992; Leffall, 1990; Nickens, 1991; U.S. Department of Health and Human Services, 1985). These studies implicitly affirm that wellness and preventive care systems have never been as accessible to non-White ethnic/racial populations (hereafter referred to as ethnic/racial populations) as they are to Whites. This issue is an important one that ethnic/racial communities and health care providers must address if meaningful change in health risk behavior is to occur. It is futile to continue to point to the health disparities between ethnic/racial populations and majority-group citizens without making forthright efforts to address these disparities. Approaches to model interventions that have validated positive results with ethnically diverse populations should be widely marketed and replicated. Such approaches must embody culturally relevant and appropriate strategies for systems change. Concomitantly, risk reduction in lifestyle behaviors has a positive benefit on the community at large and facilitates health cost containment.

Culturally sensitive interventions for achievement of the "Healthy People 2000" objectives incorporate viable programming strategies to reach the hard-to-reach ethnic populations (U.S. Public Health Service, 1991). For African Americans, several major health promotion objectives have been given high priority. Among these objectives are the following:

- Reducing infant mortality from the 1987 level of 17.9 deaths per 1,000 live births to 11 per 1,000.
- Reducing growth retardation among low-income Black children younger than age 1 from the 1988 level of 15 percent to less than 10 percent.
- Reducing the maternal mortality rate from the 1987 level of 14.2 per 100,000 live births to 5 per 100,000.
- Reducing cigarette smoking from the 1987 prevalence level of 34 percent to 18 percent.

- Reducing cirrhosis deaths among Black men from the 1987 level of 22 per 100,000 to 12 per 100,000.
- Reducing coronary heart disease deaths among Blacks from the 1987 level of 163 per 100,000 to 115 per 100,000.
- Reducing the number of homicides among Black men aged 15–34 from the 1987 level of 90.5 per 100,000 to 72.4 per 100,000.

Consensus is evident in social scientists' definition of cultural appropriateness and relevance. Culture has been traditionally defined to imply an integrated pattern of human behavior that includes thoughts; communications; actions; customs; values; belief systems; social forms; and material traits of racial, ethnic, religious, or social groups. Some older African Americans, for example, believe that having a medical-surgical procedure and allowing organs to be exposed to air will lead to a more serious outcome than not having surgery at all. The Jehovah's Witnesses religious denomination rejects the medical practice of blood transfusions. This policy translates into a normative cultural practice based on a religious belief system. In some subcultures the acquisition of manhood is linked to young boys' losing their virginity. In many Third World cultures, polygynous relationships (wherein there is more than one wife) are an accepted countrywide norm. In other subcultures, it is typical to apply salt to one's food before ever tasting it. In the U.S. drug culture, a typical practice involves the sharing of paraphernalia and intravenous needles. Traditional Western cultural standards would view all of these behaviors as high risk and inappropriate for healthy living. Such traditional Western perceptions represent only the tip of the iceberg when one considers the insensitivity of mainstream interventions designed to address health promotion interventions across these culturally different value systems.

In light of the foregoing, those who work in the field of health promotion should strongly consider the role that cultural beliefs have in consequent health promotion programming. One must consider the contextual, cultural, and subcultural group-specific data about the target populations' socioeconomic status variables; their awareness and attitude toward disease and wellness; their

perceptions of what constitutes high-risk behaviors; and their degree of participation in such high-risk behaviors.

Barriers to Change

On the national level, several barriers to the inclusion of ethnic minorities in health promotion programs exist. Social-economic status can be a barrier, since many employed persons do not have access to health and wellness programs through their employee benefit package. Moreover, unemployment itself means that one may not have health benefits. In addition, low literacy levels, poor education, substandard housing, and related social and environmental variables are known to correlate positively with the lack of access to health and wellness programs. This observation has been exacerbated for ethnic/racial groups, and African Americans in particular, by virtue of situational factors and negative social forces.

Institutional racism is a specific barrier. This barrier refers to the policies and practices of institutions that systematically exclude or discourage ethnic clients from fully participating in preventive health behaviors. An example of institutional racism is the disproportionately high number of alcohol and tobacco billboards in ethnic/racial communities. Another example is the poor quality of produce available from neighborhood grocery stores in low-income communities.

The lack of appreciation of cultural differences often leads to misunderstanding and distrust. Disenfranchised individuals might not return for a followup health visit if on the first visit they are confronted with a rude, "too busy" health care provider who fails to communicate genuine concern and caring. Although many health care providers try to pay attention to cultural nuances, their cultural diagnosis is often limited by assumptions based on such factors as color, language, or clothing. Some health and human service agencies attempt to address the cultural diversity issue by translating brochures from English to the language of the target group, by having ethnic-specific role models in print material, or by hiring a staff person from the ethnic/racial target population. Even though it is desirable to have providers from

the same culture as the client population, this practice alone will not enhance the quality of culturally relevant and responsive health promotion systems. Any effort to change culturally determined values and beliefs addressing illness or disease must emerge from a thorough understanding of and respect for that culture (Braithwaite, Murphy, Lythcott, & Blumenthal, 1989). Such sensitivity is rarely manifested by health systems that service culturally diverse communities.

Some prevention specialists (Orlandi, 1992; McAlister, Puska, Saeanen, Tuomilehto, & Koskela, 1982) argue that culture is pertinent to various domains of health behavior, given the endogenous traits of individuals, their behavior, and the milieu within which that behavior manifests the dynamic interaction commonly referred to as reciprocal determinism. The reciprocal determinism construct helps one recognize that diseases can be prevented. A community-based and public-health-oriented planning process that highlights lifestyle reorientation and culturally relevant intervention to change behavior must be central to the basic approach.

During the past 20 years, the social movement resulting in community-based approaches to health promotion has gained great momentum. This social movement evolved first from the awareness that behavior and culture shape each other reciprocally, and second, from the recognition that the major causes of morbidity and illness are preventable through changes in collective and individual lifestyles (U.S. Public Health Service, 1991).

The Cultural Competence Continuum

The work of Bazron, Dennis, and Isaacs (1989) in developing a culturally competent continuum scale is relevant to this discussion. These authors advance the definition of cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations (p. 13)." Competence implies having the capacity to function effectively. A system that is culturally

competent acknowledges and incorporates at all levels the essential nature of the assessment of cultural knowledge and the flexibility of service delivery to address culturally diverse needs. Cultural competence is a goal that health and human service agencies strive to achieve in their approach to underserved populations. It involves a developmental process of becoming increasingly sensitive to the unique needs of the underserved population and recognizes that there is always new knowledge to be acquired about cultural groups that are different from one's own. The cultural competence continuum ranges from cultural destructiveness to cultural proficiency with cultural incapacity, blindness, precompetence, and competence between the extreme end points, as shown in figure 1.

Elements of Cultural Competency	Key Managed Care Elements	Operational Impact
Attitudes	Leadership	Access
Beliefs	Board Composition	Service Design
Knowledge	Vision & Mission	Clinical Service Skills
Skills	Operational Policies	Service Utilization
Language & Communication	Marketing	Human Resources
Resources	Cultural content must be	Medical Necessity
Community Analysis	adopted, incorporated,	Continuing Education
Valuing Diversity	& legitimatized by	Credentialing
Cultural Self-Assessment	leadership from the	Supervisory
Dynamics of Difference	vision, mission, & policies	Development
Institutionalization of Cultural		Management
Knowledge		Information
Adaptation to Diversity		Quality Management
Role of the Family		Utilization
Role of the Church & Religion		Management
Role of Schools in the Community		Quality Assurance
		Public Relations
		University Curriculum
		Daily operations of the
		system must reflect
		cultural competency

Figure 1.   Impact of cultural competency on core of managed care

A brief description of the stages of this continuum follows:

- *Cultural Destructiveness.* This is the active engagement of cultural genocide or the purposeful destruction of a culture. An example is the Exclusion Laws of 1885–1965 (Hune,

1977), which prohibited Asians from bringing spouses to the United States; meanwhile, immigration quotas restricted their migration. Another example is the infamous Tuskegee study (1932–1972), in which African-American males were exposed to the syphilis virus without their knowledge and denied treatment even after penicillin was known to be an effective treatment.

- *Cultural Incapacity.* The agency assumes a paternalistic posture toward minority groups. In this context there is a disproportionate application of resources, discrimination against people of color on the basis of whether they "know their place," and belief in the supremacy of the dominant culture. Racist policies and stereotypes typify this point on the continuum.

- *Cultural Blindness.* Persons and agency representatives fixed at this point believe that color and culture make no difference and that all people are the same. They believe that what is good for the goose is good for the gander; or what works for Whites will work for all. Although this viewpoint is liberal in orientation, it ignores cultural context, encourages assimilation, and blames the victims for their circumstances. Thus, a deficit model perspective and orientation is viewed as normative.

- *Cultural Precompetence.* This implies movement toward the realization that traditional models do not work with culturally different groups. Agencies at this point on the continuum try new approaches, hire ethnic/racial staffs, provide sensitivity training for all staffs, conduct needs assessments of ethnic/racial communities, and involve ethnic/racial persons in decisionmaking.

- *Cultural Competence.* This position is characterized by acceptance and respect for differences; careful attention is given to the dynamics of differences. There is a recognition of internal ethnic group difference and an appreciation for leadership provided by ethnic/racial persons. Culturally competent agencies understand the interplay between policy and practice, and are committed to policies that embrace services to diverse populations.

- *Cultural Proficiency.* Culturally proficient agencies seek to add to the knowledge base of culturally competent practice by conducting research, developing new service delivery approaches based on cultural context, and publishing and disseminating results of demonstration efforts. These systems hire personnel who are specialists in culturally competent practice. These systems advocate multilevel systems change and societal change for responsive implementation of health and human services programming. Multiculturalism is a norm and valued at the highest level of agency operations.

Principles for Culturally Appropriate Practices

There is little consensus on standards for culturally appropriate practices regarding health promotion. However, considerable agreement exists on principles useful in achieving positive health outcomes as a byproduct of getting people to take charge of their health behavior. All people, even those most impoverished by every index of social functioning, desire good health and self-determination. Too often, however, the goal of achieving genuine participation in active decisionmaking to govern one's community and the health programs that serve it has been stymied by well-intentioned yet naive health educators. By virtue of their education and training, they believe they know the best way to address complex problems that involve promoting health education to a population. In ethnic/racial communities, developing culturally and linguistically appropriate health promotion priorities, interventions, and goals requires a "bottom-up" approach (i.e., the active participation of affected community members in the design, implementation, and evaluation of the intervention). This approach can be facilitated via ethnography and related qualitative research procedures.

Other principles that should be incorporated with community-based culturally sensitive models include (1) sharing leadership; (2) acquiring input from the affected group at all per-

tinent decision points; (3) building consensus among health coalition members and the constituents they represent; (4) establishing ground rules for operational purposes (this may translate into generating and ratifying bylaws and memorandums of agreements); (5) reviewing for consideration and potential adoption the suggestions of reference group members; (6) preferring group capacity building over paternalism; and (7) appreciating individual differences and diversity.

Health and human service organizations are beginning to recognize the utility of a community outreach component for supporting and maintaining responsive programs. In essence, such support means that the organization's Chief Executive Officer (CEO) must be an advocate for citizen involvement in program planning activities. Multiculturalism is also an important perspective for CEOs to accept in order to be credible proponents for addressing the needs of diverse populations. In addition, CEOs must be willing to commit human and fiscal resources to support citizen involvement in generating culturally appropriate strategies.

Implementation steps for advancing a culturally appropriate approach to health promotion might include the following:

- Convene a representative body of the target reference group for the purpose of brainstorming on important health and community issues.
- Conduct a review of the extant literature on related health issues regarding the cultural group.
- Consult with local and national advocates on cultural sensitivity to implement workshops and seminars on racism, sexism, and classism throughout the levels of the organizations. This move will demonstrate the commitment of senior management to the process of institutional change.
- Hire competent ethnic/racial community role models for management and line positions.
- Establish policies in the organization that support and encourage the inclusion of protected classes in all levels of the organization.

Model Approaches to Culturally Based Health Promotion Systems

A few exemplary approaches exist that have implemented culturally based health promotion practices and systems. In many Third World countries the U.S. Peace Corps has employed a community organization and development approach. Such an approach relies on significant input and involvement of indigenous residents in the decisionmaking process. Encouraging local residents to empower themselves stimulates self-reliance and self-determination. In the United States, a model approach to providing health care in which the local community is genuinely consulted as a valued aspect of the health system is the community-oriented primary care (COPC) model. This approach advocates a strong bond and partnership between patient and physician. The principles of COPC have provided the philosophical foundation of publicly funded health programs for many years. They expand the primary care model to include a defined population and a process by which the health problems of that population are systematically identified and addressed. Nutting (1987) suggests that in this marriage of the principles of epidemiology and the practice of primary care, COPC challenges practitioners to broaden their scope of concern beyond the care of the individual patient.

The basic COPC model consists of three essential components: a primary care program or practice, a defined population, and a process by which the major health problems of the community are addressed. The term "primary care program" or "practice" means that an array of personal health services are accessible and acceptable to the patient. These are comprehensive in scope, coordinated, and continuous over time. The practitioner is accountable for the quality and potential effects of the services. While all three components are expected to vary widely across implementation sites, each should be represented in some form.

In some settings, the COPC practice will address "true" communities, that is, those sharing common social, cultural, economic, and political systems. Although involving the community is an important feature of COPC, the manner and extent to which com-

munity residents participate in the collaborative process can vary widely. The critical roles for the patient and community participants are to develop a "denominator bias" and to represent the interests of the entire target population while participating in the function of the COPC process.

A fundamental component of the model is the process by which the major health problems of the community are identified and systematically addressed. This process consists of activities that fall into four categories: (1) defining the characteristics of the community, (2) identifying the community health problems, (3) developing emphasis programs, and (4) monitoring the impact of program modification. If these components are incorporated with the genuine involvement of the target population, cultural sensitivity and relevance will be built into the implementation design by virtue of the community ownership of the health problem(s).

COPC and other partnership models seem to be working. They represent advancements in the repertoire of strategies for bringing consumers and providers closer to finding common ground for community health goals and expectations. From these and similar approaches, it is clear that involving the community in the planning phase of any new initiative is critical. Failure to do so inevitably leads to isolated and ineffective programs. Equally important is "starting where the community is," that is, first addressing the problems that people in the community view as most critical, even though the epidemiological literature may indicate that other health problems are more severe. The involvement of community members in the planning process will help gain acceptance of emerging health interventions delivered in a cultural context. Planning done in a vacuum is doomed to failure. Balance as it relates to gender, age, ethnicity, and socioeconomic status is also important if the intervention is to have widespread community interest and endorsement.

Multilevel Systems Change

As noted earlier, Orlandi (1992) reports that the most effective community-based health promotion efforts have as their theoretical premise the principle of reciprocal determinism. Of

importance here is the individuals' dialogue interface, their behavior, and their environment. For community-based interventions to be responsive to intended audiences, the approach should include multiple components targeted at multiple organizational levels and directed at multiple target audiences within the community. Orlandi states, "The public health model aims interventions at the host (individual), agent (e.g., tobacco product manufacturers), and the environment (community laws, norms, mores, culture, etc.). Programs designed in this way can reach large numbers of individuals with cost-efficient interventions that are easily replicated (p. 11)." Contrary to popular belief, however, a significant problem exists with efforts to replicate this traditional public health model across ethnically diverse populations, particularly when one considers the great variability within ethnic/racial groups and across geographic regions.

Orlandi (1992), Thomas (1990), and Braithwaite et al. (1989) argue for the significant and meaningful involvement of community residents and community organizations in the conceptualization, development, and ownership of health promotion programming, rather than top-down agency-initiated programs. Such an approach requires that agency program deliverers acquire good listening skills and have the capacity to understand, translate, and interpret information from a multicultural perspective. In other words, having the capacity to relate genuinely to persons different from the dominant culture is a sine qua non for effective and responsive behavioral change. This approach is not new; it builds on the Model Cities movement of the 1960s in which citizen participation was a key element. More recently, several private organizations (Kellogg Foundation, Robert Wood Johnson Foundation, Kaiser Family Foundation) and federal agencies within the DHHS (Center for Substance Abuse Prevention, Office of Minority Health, National Cancer Institute) have bought into the multilevel systems change and community partnership model of planning interventions based on a bottom-up approach. Although this approach has great promise, there is still a problem with some initiatives, given their token ethnic/racial group participation.

During the 1980s and 1990s, cultural anthropologists have shown increasing concern with issues of ethnicity as they relate to medical care and the delivery of health services. Ethnographic methods and qualitative research have proven effective in assessing the health needs of subcultural groups, patient perceptions of the medical establishment, emic (relativistic) concepts of illness and disease, and the structure of patient support networks. Problems in patient-clinician interaction have been examined, as have obstacles to patient use of existing health services. Much emphasis has been placed on primary care at the community level.

Hence, even though cultural sensitivity is extremely crucial to successful health promotion programming for the African-American community, a larger challenge is to reeducate this group about its historical roots in Africa and to reinforce the positive events in African-American history. This challenge is particularly great for today's adolescents and young adults. Many of them wear the symbolic X to represent a connection with Malcolm X. Yet prior to Spike Lee's movie about this heroic figure, these youngsters had little substantive knowledge about the philosophy or history of Malcolm X. Therefore, for health education and promotion programming to be effective from a cultural context with this vulnerable group, a habilitative approach is necessary to reeducate these youth about their cultural heritage and ethnic genealogy. At a minimum, vignettes relative to African-American history should be incorporated into health promotion efforts so as to employ the dual emphasis of converging culture with health education programming. Such an approach is indicative of a required change in typical health education systems.

The Value of Qualitative Research

To assess population needs and improve the delivery of health services, qualitative research is especially appropriate for data collection when issues of ethnicity and health care are concerned. Primary care researchers are involved in the human experience of health/illness situations, and the qualitative research paradigm lends itself to people-centered methods. It aims to discover

features, patterns, attributes, and meanings of the health/illness phenomena under study (Leninger, 1990). Rather than isolating people as study subjects, qualitative research *involves* "informants" or "participants" in the study. Much of the practice of primary care places emphasis on how individuals and families make sense of, cope with, and respond to illness (Tom-Orme, 1991). Strauss and Corbin (1990) and Carey (1993) also emphasize the importance of combining qualitative and quantitative methods to build research instruments, illustrate findings, develop policy, expand basic knowledge, and evaluate demonstration or intervention projects when testing the efficacy of models across ethnic/racial groups.

Finally, anthropologists have noted that because patients' health beliefs and practices are embedded in a broader context of community norms and values, in some situations community education may be more effective than clinic-based individual counseling. Social marketing used in the service of community education is a promising strategy for changing health behaviors and attitudes (McLorg & Bryant, 1989):

> *A distinctive feature of social marketing is its reliance on qualitative research to identify a target audience's perceptions concerning a health practice and the use of these data in formulating intervention strategies. Insights gained from marketing research can be used for developing messages most appropriate for a particular audience, identifying the best media channels and most credible sources for reaching the audience, and evaluating the impact of educational materials on behavioral change (p. 275).*

Conclusion

Researchers who employ ethnographic techniques are expanding their collaboration with community leaders and members of the health services network to collect data that will lead to more effective intervention strategies and more efficient delivery of services to ethnically diverse populations. This trend is promising and productive and should contribute to community empowerment in the field of primary care and risk reduction for

self-defeating behaviors. These investigators realize that there is no instantaneous resolution to the complex issues involved with advancing culturally sensitive health promotion at the community level. Systems change and modification of systems practices can best be confronted via a simultaneous multilevel and multifaceted approach that involves individuals, communities, and agencies.

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7

Race, Health Status, and Managed Health Care

King Davis, Ph.D.

Introduction

Public policy interest in the health status of African-American populations, as well as the extent to which their status differs from Whites, has been evident in the literature for decades. National interest in the relationship between health and race will assume even greater importance as efforts are made to increase the numbers of African Americans (across all income classes) in cost-effective managed care plans through Medicaid, Medicare, or employment-based insurance. These new market segments, distinguished by race, language, income, and differences in lifestyles and help-seeking behavior, represent both major service challenges and economic opportunities for managed care plans. To serve this heterogeneous market most effectively and economically will require managed care plans to understand the significance of cultural differences and cultural competency in service design; access; clinical standards of quality, service utilization, outcome evaluation; and human resources.

Defining Basic Terms

Three basic terms are important to understand the relationships among race, health status, and cultural competency: managed care, cultural competency, and access.

"Managed care" is defined in this chapter as any insurance plan, procedure, process, program, or policy designed to affect access, cost, quality, or outcome of health care services. The objective of managed care insurance is to effectively manage each of these elements so as to deliver the quantity and quality of service needed at the optimum cost. To achieve its goals of cost efficiency and quality service, managed care plans require considerable knowledge and information about the consumer, provider, and system, as well as the clinical processes used to prevent, diagnose, treat and evaluate an encounter of service. In this regard, managed care is a data-driven and data-dependent process. Where data and information are inaccessible or inaccurate, managed care plans cannot achieve their goals of cost efficiency and quality of service.

"Cultural competency" is the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes. It can be hypothesized that the more a health care plan is based on cultural competency, the greater the probability the goals of cost efficiency and quality services will be achieved. There is a clear need to increase the knowledge base regarding the interface between managed care and cultural competency.

"Access" is defined as the extent to which an individual, group, or population has an opportunity to use the resources inherent in the health care system. One of the most seminal concepts in the interface between managed care and cultural competency is access. Theoretically, access to health care resources can be measured on three levels: fully opened access, partial access, and fully closed access. Resources of the health system are considered necessary to enhance, sustain, or maintain life and years of healthy living. African Americans' access to health care resources has increased but remains limited in some market segments by a plethora of factors: poverty, unemployment, absence of health insurance, preexisting conditions, lack of information about service, inaccessible geographic location, limited numbers of pro-

viders, cumbersome regulations, and a failure on the part of the provider to understand the language and culture of the consumer. The Robert Wood Johnson (RWJ) Foundation (Center for Health Economics Research, 1993) concluded that a "lack of access means people use fewer health services and have poor health outcomes" (p. 6). Limited access leads to poor health outcomes for minority populations and to increased demand for services and higher costs for managed care plans in the long run. The foundation lists a number of indicators of access to health care. These include family planning, prenatal care, immunization, cancer screening, regular health visits, and dental checkups. In each of these areas, the foundation indicates that minority populations, particularly poor African and Hispanic Americans, have limited access and in many instances higher rates of acute illness and chronic debilitating diseases but lower rates of ameliorative surgery or hospital care.

Linking Race, Health Care, and Employment

Managed care is essentially an indemnity health insurance program in which benefits are tied to full-time employment or eligibility for public welfare assistance. Although revisions in public welfare policy have incorporated managed care principles and organizations in Medicaid, there is a clear expectation that recipients of Aid to Families with Dependent Children (AFDC) will exit the rolls in 2 years and obtain continuing health care coverage through gainful employment in the private sector. Medicare, too, has incorporated managed care principles, but benefits remain linked to a history of employment or prediction of the person's long-term employability. What is clear is that health care access and employment are integrally linked in the United States. Populations that have high rates of unemployment, that work in settings without health benefits, or that have extensive preexisting conditions are less likely to have fully opened access to health care services. In all too many instances, unemployment, underemployment, and preexisting conditions are correlated with race and lower income.

A greater frequency of physical illness, poor environmental health conditions, and excess rates of mortality in some segments of the African-American population have long been described in professional papers and literature (Blanton, 1931). At times, this literature has erroneously conceptualized the African-American population as homogenous in sociodemographic and health characteristics (U.S. Department of Labor, 1966). One reason for this long public policy interest has been the projected increase in economic and social costs of accessing health care by a population that has long-term double-digit rates of unemployment, lower rates of personal health insurance, and a large number of low-income members. Some mortality and morbidity data suggest that chronic and acute illness, long-term disability, and early death occur more often in some segments of the African-American population, potentially increasing the overall costs of their health care (U.S. Department of Commerce, 1995). If this conclusion is valid, the graduated cost of care for segments of the African-American market will be a significant factor for managed care plans, increasing their economic risks and decreasing the attractiveness of enrolling these market segments as covered lives. A second reason for the public policy interest has been the need to understand the relationship between health care of African Americans and their lower than expected rate of participation in the labor force. It seems reasonable to assume that higher frequencies of acute or chronic illness in African-American populations are likely to decrease the number of days of annual and lifetime employment. A third reason has been the need to resolve the legal, ethical, and political dilemmas associated with inequitable access to health care for lower income African Americans, when limited access and poor quality of care translates into higher than expected rates of excess deaths. As political and economic pressures increase to shift the service and payment mechanism in American health care from fee for service to managed care, a number of critical public policy issues must be raised and debated. These not only concern the linkages among race, health status, and income but, more important, how the concept of cultural competency can improve quality of care and outcomes. If managed care is to stem the escalating costs of health care while increasing

access and years of healthy living, culturally competent approaches may offer new cost-effective insights into how to design, market, deliver, and measure quality service to African Americans.

One of the earliest references to the importance of maintaining the health of African Americans was based on the deleterious connection between poor health and the inability of slaves to continue work (Blanton, 1931). Ironically, health care needs of African Americans in a chattel-based economy precipitated some slave owners to provide the first employer-financed health care in America, albeit as a forced benefit, in order to protect their human capital investment (Blanton, 1931). When slavery ended, one of the major dilemmas for African Americans (and for the Federal Government) was the need to replace plantation-based health care in the market using Blacks' own limited resources, Federal subsidy, or alternative healing practices.

The relationship among employment, income, and health benefits that was established during slavery remains important for many segments of African Americans in the current debate over managed care policy and access to health care for the poor. Managed health care plans are almost exclusively employment-based fringe benefits. A relatively small group of unemployed women and children acquire their health care services via public transfer payments such as AFDC (RWJ Foundation, 1991). As welfare reform policies are implemented, these women and their children will be required to acquire health benefits in the labor force. The association of managed care with full-time employment when juxtaposed with historically high levels of unemployment among African Americans raises the potential for significant portions of this population (particularly unemployed and underemployed Black men) to be excluded or displaced from health care plans. It is clear that the relationship among race, health status, and work remains important to understanding the dilemmas of transforming the American health care system from a fee-for-service reimbursement system to managed care. However, the relationship among race, health status, and work and its potential impact on managed care policy and principles remains poorly conceptualized and minimally understood.

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Current Health Status of African Americans

The health status of Americans has been examined and described recently using two related measures. One approach, developed by the RWJ Foundation (Center for Health Economics Research, 1993), uses the concept of access indicators to determine the level of use of health services and the outcomes of those services on the individual, group, or population as a whole. Access is conceptualized as the extent to which a population uses health services and the nature of the outcomes from that service. The RWJ Foundation proposes that change in either the level of use or outcomes for a population is indicative of a change in access. Longitudinal data and information is useful for identifying and charting these trends and patterns and for using them as the basis for recommended changes in such public health policies as the Health Maintenance Organization Act of 1973 and its amendments.

One major dilemma that limits understanding of the health status of African-American populations is the absence of quality data on patterns of access to and use of health care by social class (Center for Health Economics Research, 1993). Although some data on African-American experiences within the health system have been developed and maintained for decades by State and Federal agencies, these efforts have not produced an integrated set of data that facilitates longitudinal comparisons. In far too many instances, such data have not captured the differences in health care needs and patterns among various income segments of the African-American population. While quality health care data for the American population as a whole are limited, the RWJ Foundation specifically notes the need for increased research attention to this area for minority populations.

The Federal Government (Erickson, Wilson, & Shannon, 1995) uses the concept of years of healthy life (YHL) as a second means for conceptualizing, measuring, and comparing health status across populations. The Federal measure assesses traditional concerns (mortality and morbidity) along with quality-of-life indicators. While recognizing the importance of traditional measures, the Federal indices, it is believed, provide a more exhaustive means

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of determining health status and the impact of various public policies and service approaches.

When applied to African-American populations, each of these two approaches to measurement yields helpful data for identifying the health status and problems of segments of this population and the potential relationship to income, employment, managed care, and cultural competency. The Federal YHL indicator concludes that there is a gap of 9 years between Blacks and Whites in America (Erickson, Wilson, & Shannon, 1995). The following discussion of three of the traditional outcome indices used by the RWJ Foundation will help clarify the role of race, the need for public policy intervention, and the potential role for culturally competent interventions.

Life Expectancy

Life expectancy is an important measure used by the RWJ Foundation for estimating degree of access, use of services, outcomes, and, indirectly, years of healthy living. The Federal indices compare these traditional measures with years of healthy living. In 1990, total life expectancy at birth for all populations in the United States was 75.4 years, while total years of healthy life was 64.0 (Erickson, Wilson, & Shannon, 1995). When data on life expectancy at birth are compared by race and gender for the United States, it is noted that Black men have the shortest projected life span at 64.9 years (Robert Wood Johnson Foundation, 1991). However, these data do not identify the extent to which the index for Black males' (or other populations') life expectancy at birth is differentiated by income, education, residence, employment, or lifestyle. White women continue to have the longest life span at birth (78.9 years) of all American populations, while Black women have the second highest life expectancy at birth (73.4 years)—slightly higher than that for White men (72.3 years) (RWJ Foundation, 1991). These figures on total life expectancy, when compared to the Federal YHL indicator, have significant implications by race. For example, Blacks had total life expectancy at birth of 69.1 years in 1990, while their YHL index was 56 years (Erickson,

Wilson, & Shannon, 1995). Compared to Whites, the mean number of years of healthy life for Blacks was 9 years shorter in 1990.

What is clear from these data is the finding that Black men tend to have a 7.4-year gap in life expectancy at birth when compared to White men, a 14-year gap when compared to White women, and an 8.5-year gap when compared to Black women. It is not clear from the data whether different segments of Black males are more vulnerable to shortened life spans or abbreviated years of healthy life. Black males are the only group described in the literature to have experienced a decline in the life-expectancy-at-birth indicator over the past several decades. These differences in life expectancy at birth and the gaps by race and gender may reflect delimited access or vulnerability of these various groups to a series of diseases, conditions, and life events—many of which are preventable or potentially responsive to early detection and intervention. However, early detection and intervention require regular access to the health care system, which is often compromised for African-American populations. Future research and data collection efforts will need to make clear the distinctions within categories to assist public policymakers and managed care plans to identify the level of risks associated with different population segments and to design segment-specific services for them.

Five conditions differentiated by race and social class account for the majority of adult deaths in the United States. The leading cause of death for the American population is heart disease, followed by deaths from cancer, stroke, accidents, and respiratory illnesses (RWJ Foundation, 1991). The death rates from these five conditions are influenced by such factors as age, gender, income, education, and race (RWJ Foundation, 1991). For example, deaths from heart and circulatory causes are relatively infrequent until ages 24 to 44. Furthermore, the frequency of standard medical interventions for heart and circulatory diseases is correlated with race and income (Center for Health Economics Research, 1993). These life-saving procedures are used with less frequency with Black and poor populations despite limited differences in occurrence of heart disease by race. Even in those medical programs that are supported by public dollars—for instance, Medicare and

Veterans Administration Health Services—there are major differences by race and income in the extent to which life-saving surgical interventions are used (RWJ Foundation, 1991). These conditions and the differences in modes of intervention suggest that early intervention, prevention, education, and access to equitable quality health care have not been as available to segments of African Americans under fee-for-service plans. Inaccessibility may lead to and exacerbate poor health status, shorter life spans, and shorter years of healthy life. An important consideration for managed care policy is to determine how to use knowledge about prevalence, incidence, and differences in access to services to build cost-effective systems of care that will extend the years of healthy living for African-American populations.

Infant Mortality

Significant declines in rates of infant mortality have been attained in the United States (and other industrialized nations) during the period of 1900 to 1990 (RWJ Foundation, 1991). The overall infant mortality rate in the United States in 1988 was approximately 10 per 1,000 live births. However, the 1988 rate (17.6) for Black infants was 76 percent higher than the national mean, and slightly more than twice the rate for White infants (8.5) (RWJ Foundation, 1991). A similar pattern by race is noted in neonatal deaths for 1988. For example, the rate for blacks was 11.4 per 1,000 live births, while the rate for Whites was 5.4 per 1,000 live births (RWJ Foundation, 1991). Rates of infant and neonatal mortality have shown major disparities by race for decades (U.S. Department of Commerce, 1971). In 1900, while rates were very high internationally, the rate for non-White infants was 333.9 per 1,000 live births and the rate for White infants was 159.4 per 1,000 live births (U.S. Department of Labor, 1966). By 1940, the neonatal death rate for African-American infants was 39.7 per 1,000 live births while the rate for White infants was 27.2 (U.S. Department of Commerce, 1970). Studies show that infant deaths such as these are related to a combination of factors including low birth weight, use of prenatal care, age of the mother, income, education, residence, and race (RWJ Foundation, 1991). While reductions in the influence of

these factors have precipitated a sharp decline in the rate of infant deaths overall, Black infants continue to remain highly vulnerable to death in the first year of life. These race-specific data, too, are important for managed care organizations in designing benefit packages for specific populations.

Chronic Disease

Chronic diseases include arthritis, hypertension, diabetes, mental retardation, severe mental illness, multiple sclerosis, chronic fatigue syndrome, and respiratory illnesses. These long-term illnesses have a tendency to cause long-term disability, limit capacity for employment, and reduce the number of years of healthy life. These disabilities may also increase the overall cost of health care, including group rates and individual premiums, because of the extensiveness and length of care required. Because of the increased economic risks that are associated with enrolling and serving individuals and groups with long-term illnesses, managed care benefits may be limited to these groups. Age, gender, race, and income differentiate chronic conditions. For example, more African Americans per 1,000 cases develop hypertension and diabetes than do Whites. Black women have higher rates per 1,000 cases of each of four chronic conditions—arthritis, hypertension, diabetes, and respiratory illnesses—than do Black men. The rates of hypertension per 1,000 cases (171) and diabetes (45) for Black women exceed the rate for all other groups (Robert Wood Johnson Foundation, 1991). When the number of days of lost work or other activities that stem from illness and disability are considered, there is a relationship with income and race. While low-income populations have the highest number of lost days of work and activity related to illness, this pattern does not hold when race is included (RWJ Foundation, 1991).

When the rates of preexisting chronic conditions are high, the economic risk for managed care plans is increased. Increased economic risk can translate into efforts to deny coverage for long-term or preexisting illnesses, or increased cost of premiums. Since it is noted that identifiable segments of the African-American population (particularly Black women) are more susceptible to chronic debilitating illness, this susceptibility may result in less available

coverage and limited service for these segments of the African-American population under capitated managed care plans.

Health Insurance Coverage and Race

In the period 1987 to 1993, close to 80 percent of African Americans were covered by either employee-based or governmentally backed health insurance (U.S. Department of Commerce, 1995). Slightly more than 20 percent of African Americans did not have any health insurance coverage between 1987 and 1993. During the same period, close to 86 percent of Whites were covered by either private or public health insurance, while 14 percent lacked coverage. Although there is not any significant difference in the proportion of the population with some form of health insurance by race, there is a marked difference in the source of coverage. Close to 75 percent of the White population received health insurance from the private sector, in most cases as a fringe benefit of employment. However, only 50 percent of the Black population received insurance coverage as a benefit of employment. Contrary to the pattern (9 percent) found in the White population, close to 30 percent of African Americans received their health insurance from either Medicaid or Medicare.

Close to 20 percent of the African-American population lacks health insurance from any source. For the White population this figure is close to 14 percent (U.S. Department of Commerce, 1995). The RWJ Foundation (1991) indicated that 36 million Americans lacked any form of health insurance in 1987. African Americans, who comprise 10 percent of the U.S. population, constitute 20 percent of the persons who lack any form of health insurance.

Preliminary Conclusions from the Data

The data, which suggest that the health status of African Americans is compromised by limited access to health care systems and resources, lead to a number of preliminary conclusions that are

potentially useful as background in linking managed health care policies to cultural competency:

- African Americans are a highly diverse and heterogeneous population.
- Mortality and morbidity are related to race, income, and employment.
- African Americans are disproportionately represented in poverty.
- Data and information about health and help seeking among African Americans are limited.
- Segments of the African-American population have higher than expected frequencies of health problems but limited access to service.
- Fee-for-service health care did not prevent the occurrence of chronic health conditions in African-American populations, nor ensure years of healthy life.
- Help-seeking and help-utilization patterns are influenced by social class and race.
- Access to quality health care, even when costs are subsidized, is influenced by the race of the consumer.
- Segments of the African-American population suffer disproportionately from chronic health conditions that may increase the cost of care and insurance premiums.
- Access to health care is integrally linked to employment, insurance coverage, and race.

Conceptualizing the Intersection Between Managed Care and Cultural Competency

Managed care and cultural competency have heretofore been separate linear concepts. Managed care as defined in this chapter had its origins in the latter part of the 1880s in Germany and the United States (MacLeod, 1995), while cultural competency was defined initially by Cross, Bazron, Dennis, and Isaacs (1989). However, the need to successfully extend managed care services to a broad-

ening array of minority markets opens up opportunities for the interface between the two concepts. There are three opportunities in which the concepts of managed care and cultural competency have logical value operationally. First, managed care plans are competing to add more covered lives from the African-American population that currently obtains health insurance as a benefit to employment. These are individuals who are employed in full-time positions and have the option to select their health care from among several plans offered by their employers. A second opportunity has developed as the Government attempts to curb Medicaid and Medicare costs by shifting 28 percent of the African-American population to managed health care plans. Approximately 3 million of these individuals will be unmarried women and their children currently receiving AFDC payments, women who historically have used hospitals and emergency rooms for primary care. The most significant opportunity, however, will be the 9 million African Americans receiving subsidized health care via the Medicare program. Medicare recipients become eligible for health care benefits based on advanced age and/or disability.

The two common denominators in both federally sponsored health programs are (1) income that limits the individual from purchasing health care in the open market and (2) recipient choice from among competing plans. In some instances, recipients will be able to exercise their choice on a monthly basis rather than annually or semiannually, as in the private sector. To reduce the rapidly escalating cost of the Medicaid programs, the Federal Government has approved waivers submitted by the States allowing them to contract with managed care plans to provide health care services to the poor. Effective and profitable transfer of these consumers to managed care plans will require a working interface between all phases of managed care services and cultural competency.

Perhaps the most significant challenge to the American health care system will come in the effort to determine how to provide health care coverage to the remaining 20 percent of African Americans who have no insurance coverage at all. These individuals have high rates of unemployment; work in jobs that do not pro-

vide benefits; or have wages insufficient to purchase personal health insurance; and yet they are not generally eligible for public welfare assistance. Because they lack disposable income or transfer payments, this population offers minimal incentives for inclusion or consideration by managed care plans or policies. Local, State, and Federal Governments and nonprofit organizations will increasingly be asked to provide health care for them.

The operational nature of managed care is reflected in the specific policies and practices that are employed to manage access, cost, quality, and outcome. These include but are not limited to the following (United HealthCare Corporation, 1995):

- Gatekeeping.
- Preauthorization.
- Copayments and cost sharing.
- Medical necessity.
- Integration of services.
- Utilization review.
- Enrollment and disenrollment.
- Shared risks and capitation.
- Disallowance.
- Utilization review and management.

These and other related managed care processes must be transformed if managed care plans are to be effective and profitable in serving African Americans.

The essential elements of cultural competency have been identified by a number of researchers and included in their assessment scales and guidelines (American Psychological Association [APA], 1993; Cross et al., 1989; James-Myers, 1995; Lu, 1995; Mason, 1995; Sue et al., 1985). APA has expressed interest in the relationship between psychological issues and culture for many years. This interest culminated in the development in 1991 of nine guidelines for practice. These guidelines emphasize knowledge, attitudes, skill, and respect for the role of families and religious beliefs; language facility; and the importance of adverse environmental background. Cross et al. (1989) identified and described a sequential series of elements that comprise cultural competency: the valuing of diversity, cultural self-assessment, dynamics of difference,

institutionalization of cultural knowledge, and adaptation to diversity. James-Myers (1995) identified three essential components of culturally competent health care systems. These included clinical performance standards, administrative performance standards, and financial performance standards. James-Myers proposes that these performance standards must become included as regular parts of the quality assurance system of the organization. Lu's (1995) approach to cultural competency gives priority to a host of human resource issues. In his perspective, it is critically important for managed care systems to help increase the pool of providers from minority communities.

Mason's (1995) approach to identifying the essential elements in cultural competency is shown in his cultural competency assessment scales. In both the administrative and clinical scales, he places emphasis on how well the clinician and administration know and are involved in the community in which the client lives. Sue et al. (1985) identified three essential factors of cultural competency: beliefs/attitudes, knowledge, and clinical skills.

These factors impact four key areas in managed health care systems and are believed to determine the overall direction and implementation of the managed care plan. The key target areas are administration and leadership; policymaking and governing boards; clinical standards and guidelines; and organizational vision and mission. The essential elements of cultural competency can be viewed as systems input or data that must be transformed into operational policies and standards by leadership, administration, and governance. The leadership (administrators, owners, stockholders, and governing board) must adopt cultural competency concepts to be included in the managed care plan. Cultural competency concepts can also be included in government or private industry contracts with managed care plans. Once leadership accepts the value of cultural competency to the delivery of service and profitability, these concepts can be meaningfully incorporated into the vision, mission, clinical standards, and operational policies of the managed care plan. From this transformation of concepts into practice policies and standards comes the coordination of day-to-day activities of the managed care plan with the essential elements of cultural competency. This

transformation can be facilitated and enhanced through the availability of assessments on the organizational and individual level of cultural competency, followed by continuing education for leadership, staff, and providers in each plan.

Conclusion

A cursory review of the history of health care in the United States shows that the major improvements in lives and extended years of healthy living have emerged from extensive development and distribution of public health prevention and treatment, more so than from costlier advances in treatment technology, common in the latter part of the 20th century. While these technologies have resulted in significant advancements in life span and key reductions in infant and maternal mortality rates, the distribution of many of these gains has been and remains uneven. Some groups, particularly minorities and the poor, have not advanced as quickly or as significantly as others. Under fee-for-service health plans, the overall health status of African Americans, Hispanic Americans, and Native Americans has improved but continues to lag behind in critical areas. These populations tend to have higher than expected risks of diseases that are considered preventable. Additionally, these populations do not have the degree of access to the health system that would result in greater utilization of life-enhancing surgery. This denial of equitable access remains a critical feature that separates Americans by race and income. Part of the reason for advancements in the health status of African Americans has resulted from increases in mean family income, gains in education, changes in diet, and an increase in standard housing. Of equal importance in explaining these changes in health has been the cultural acceptance of major public health innovations by African-American people. The reality is that all health care is cultural. People make choices in life that affect their risk of disease based on their culture—but also on the health and well-being of others around them. Conceptualization of illness, help-seeking behavior, and a willingness to follow medical advice are a reflection of cultural beliefs, values, and experiences.

These cultural factors are valid for consumers as well as for providers.

As the United States attempts to curtail the rising cost of health care through the implementation of managed care plans, the significance of culture as a factor in decisionmaking will increase. Managed care plans are truly data-driven and data-dependent processes. These plans require extensive amounts of accurate data and information about individuals, groups, communities, families, and work environments to determine service needs, interventions, costs, and risks. In this regard, managed care plans and organizations are as dependent as are other businesses on how much they know about the lifestyles, choices, and characteristics of potential markets prior to designing and implementing services or marketing them.

Once managed care plans and organizations gather data about their potential markets, they require a conceptual framework and methods for analyzing these data and converting them into market-specific services. Market-specific services become increasingly important as former service monopolies yield to increases in consumer choice. The growth in consumer choice is occurring throughout the health care system, both in employer-financed services and those subsidized by government. Market-specific services also become more important as the cultural characteristics of the potential markets for managed care services expand to include African Americans from across the income spectrum. Marketing techniques, information about health and utilization patterns, and service delivery approaches that work for other populations simply may not be appropriate for or acceptable to African-American populations. Inappropriate marketing efforts are likely to result in greater cost for managed care plans and greater dissatisfaction for African-American consumers.

The conceptual framework that seems key to enabling managed care plans to develop market-specific services for African-American populations is cultural competency. While not a panacea, the concept of cultural competency offers managed care a set of elements, assessment scales, and procedures for the difficult task of determining how to design services for the heterogeneous African-American market of consumers. This

conceptual framework also seems to offer managed care plans skills-based material for educating and reeducating staff in service delivery to African Americans. Cultural competency can serve as the basis for developing clinical standards and guidelines for practice and evaluation in managed care.

Cultural competency cannot resolve all the issues associated with developing and extending a new health service policy and approach to new markets of consumers. However, this concept offers a set of methodological strategies that can enable managed care plans to analyze communities so that key corporate and clinical decisions can be made about the nature and type of services to offer. Most important, these strategies identify the path to involving people who for decades have had little involvement in the systems, policies, or decisions made about their own health care.

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