Prevention and Treatment of Addictions Among North American Persons of African Descent: Another Look at the Disease Model

Robert S. Wright & Todd Leader

Prevention and Treatment of Addictions Among North American Persons of African Descent: Another Look at the Disease Model

African American Substance Use Patterns: A Historical Perspective

In an excellent application of the sociocultural model of substance addiction, James and Johnson (1996) chronicle the historical patterns of substance use among African Americans. Beginning their examination in pre-colonial Africa, the authors report that the use of alcohol and other addictive, mood altering chemicals was present throughout the continent. The use of palm wines and beers brewed from various grains was an integral part of the ceremonial activities and social interactions of men in African societies. The consumption of these beverages was almost entirely restricted to the group activity of men. Drinking alone was unheard of and the use of beer for the soothing of emotional needs was minimal.

The use of non-alcoholic substances such as cannabis in North Africa also has a long, pre-colonial history. Their use again seemed limited to male group activities: by travelling traders during fireside recitations, by senior men in African villages as they met in councils and various men's societies, and by warriors engaged in ceremony on the eve of battle. The use of qat, an evergreen leaf that acts as a stimulant when chewed, was widespread in northeast Africa. The sharing of colanut, a stimulant, between a male host and an honorable male visitor was a sign of great respect and hospitality in some African societies. This practice is seen repeatedly in African literature (e.g., Achebe, 1958). It is clear that in pre-colonial Africa the use of intoxicating substances was strictly defined by culture.

With the arrival of Europeans in Africa the well established cultural boundaries surrounding intoxicants began to change dramatically. European trade with Africa was heavily steeped in gin and rum. Ironically some of the earliest traders came to Africa with ships full of missionaries and liquor and left with cargoes of slaves. These distilled beverages with their much

higher alcohol contents were previously unknown in African village life but quickly became the main currency of trade.

By the 1700's the American slave trade was well established. The infamous American trade triangle brought sugar and molasses raised on slave plantations in the West Indies to New England. Here the materials were distilled into rum which was shipped to Africa and exchanged for more slaves that were brought to the Americas. This practice had a multiplied impact on African substance use. It infused unbelievable amounts of liquor into the African economy and culture, removed countless millions of Africans from their ancestral homelands and cultural context, and created a link between African Americans and alcohol production and consumption that remain until the present.

James and Johnson (1996) go on to describe the use of alcohol during the slavery period. This time was marked by a breakdown in the traditional use of substances among enslaved Africans. The European American practice of drinking to excess was influential and slave owners often permitted and promoted the use of alcohol for celebration during times when agricultural activity was slow. It is interesting to note that during this time the alcohol use was largely limited to African males. It is suggested that the African females' role in providing for the children and household of slave owners was less seasonal and required greater sobriety.

During and after the civil war there was tremendous mobility among African Americans. Many began to migrate north and urbanize. It is suggested that the resulting chaos and further dislodging from community and remaining cultural constraints encouraged the use of alcohol as self-medication. The influence of the church was also less powerful in the cities during this time. Chaos, poverty, mobility and lack of moral guidance sparked the introduction of African men and women into the marketplace of substance trafficking.

The mid to late 1800's was a period of great upheaval in American attitude and policy regarding intoxicants. The introduction of the hypodermic syringe, the widespread medicinal use

of opium derivatives during and after the Civil war, the opium wars and the resultant effects on American cities, and the introduction of cheap morphine and heroin were the problems that sparked the first war on drugs that took place in America in the late 1800's. This crusade ultimately led to the regulation of habit-forming additives to beverages and foods (it is no myth that Coca-Cola got its name from the common practice of mixing opium, cocaine and other drugs in beverages), and Prohibition.

Ironically, prohibition had a negative effect on the use of intoxicating substances in the African American communities. The fundamentalist constituencies that fronted the Prohibition movement also provided the Ku Klux Klan with the majority of its members. In a spirit of moralistic bigotry the movement used the myth of the lasciviousness of African American males as the impetus for promoting prohibition in middle class America. At the same time the speak-easies and clubs of urban African American communities became the place where vices could still be practised. Malcolm X (1965) himself testifies to this phenomenon in his autobiography. During his early adulthood, X travelled between African American urban centres along the east coast and the midwest selling drugs in jazz clubs and speak-easies to professional musicians and middle class whites who had gone slumming. Again the economic and cultural connection between African Americans and substance abuse was strengthened.

By the 1930's statistics began to show that large numbers of African Americans were numbered among American addicts. The increase in prosperity experienced by African Americans during World War II seemed only to further concentrate the population into urban areas. African American night life continued to expand and the culture of illegal gambling, gentleman pimps, heroin and cocaine traffickers became central to this culture. This culture has been recently profiled in modern cinema in the movie Harlem Knights* and in the writings of America's most widely read African American author, Iceberg Slim (e.g. 1969, 1971).

---

* Unfortunately a full and accurate citation is unavailable.

Within the last 50 years the capstone seems to have been set on the nature of African American substance addiction. The focus of treatment efforts in the 1950's and 1960's was largely middle-class white alcoholics. Even the tremendous influence of the Civil Rights movement had little effect on the entrenchment of African American urban addiction. It should be remembered that this movement was largely a phenomenon of the religious African American middle- and working-class.

It has been argued also that the rise of drug syndicate control of drug importation, production and distribution was also detrimental to the African American communities. The Italian Mafia, with its Catholic and family centered ethic was said to have entered this trade and targeted the African American communities as the primary market; apparently not wanting to deal poison to decent Americans. It is during this period that younger African Americans were systemically recruited to become experts in the preparation, packaging and sales of highly refined illicit drugs.

It can be reasoned that this well established economic connection between illicit drug trafficking and the emerging of the hyper-addictive* crack form of cocaine gave rise to the phenomenon of gangs in African American communities. Gang fixation with territory is nothing more than market definition: the use of guns and violence simply a method of protecting one's 'stash and cash'. Unfortunately, these symbols of African American criminal subculture have become so pervasive that even persons far from the centre of these activities confuse this as representative of 'Black culture'.

---

* Crack is said to be hyper-addictive not because it is more addictive than other substances but rather because of the hyper-arousal caused by the drug. Abusers of alcohol, marijuana or heroin can only engage in use until its mellowing effect kicks in. The energizing euphoria of crack use has the effect of encouraging prolonged use.

Implications for Prevention and Treatment

Peter Bell (1992) in his excellent monograph, Cultural Pain and African American: Unspoken Issues in Early Recovery, speaks about this confusion of African American culture as a fundamental issue in prevention and recovery. He argues that African Americans struggle with the idea that recovery and rejection of the drug subculture is in some way a rejection of their Blackness; that to go square is to go white. Former drug traffickers who 'leave the life' are mocked. Selling drugs is a way of 'beating the man' and 'getting over'. To go straight and get a job as a janitor or to raise one's family on welfare is to be an 'Uncle Tom'. Given the pervasive nature of the drug subculture in many African American communities, going straight might mean having to leave the community altogether. Surely, this is a sign that a person is turning their back on what it means to be Black.

The dynamic creates a tremendous barrier for African Americans seeking to avoid what could be characterized as the Black criminal subculture (drug addiction, theft, prostitution, pimping, gambling, conning, gang membership, and gun acquisition and distribution). There is little motivation from within the system to escape it and, until just recently, the African American leadership seemed unwilling to address the problem (James & Johnson, 1996).*

Modern treatment and prevention efforts then must counteract this powerful subcultural milieu and extend a powerful, relevant hand which is knowledgeable about the history, sensitive to the struggle for racial identity, and able to affirm that Blackness can and does exist outside of the criminal subculture.

---

* The powerlessness of African American leadership is hinted at in James and Johnson (1996). The author of this present work believes there is a direct connection between the middle- and working-class nature of the Civil Rights movement and the inability of African American leadership to effectively address this problem. Though little time is spent on this issue here let us remember that the Montgomery bus boycotts which sparked the movement was largely an issue about the desire of working- and middle-class African Americans to be able to travel back and forth to work in dignity. The success of the boycotts did little to change the lives of those who had no job to go to nor funds to travel the bus for recreation.

Alternatives to the Disease Model

> Disease: A morbid entity characterized usually by at least two of these criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomical alterations (Spraycar, 1995, p.492).

The concept that alcoholism may be a disease has been written about for over 2400 years. Nevertheless, the treatment of its sufferers has been wide and varied, including: isolation, incarceration, other institutionalization, medical treatment, and religious censure. By the late 19th Century however, alcoholism was firmly rooted as belonging to the medical profession for its diagnosis and treatment (Pittman, 1988). No doubt the establishment and success of Alcoholics Anonymous (AA) has contributed to the pervasive nature of the alcoholism-as-disease model. The later establishment of similar 12 step programs to address other addictions may explain the similar adoption of the disease model in approaching other addictions as well.

Though the disease model of alcoholism has contributed much to the development of treatment strategies it has a weakness. It does not leave a tremendous amount of room for the treatment of psychological and sociological factors which may be contributors to the prevalence and unique manifestations of addiction within specific populations'. Within the field of alcohol prevention, five models of understanding substance use have been suggested: proscriptive, socialization, public health, distribution of consumption, and sociocultural (Wright & Watts, 1985). It may be that these models provide alternative windows on addiction which are more effective in explaining the process in a diversity of communities.

The *proscriptive* model of substance abuse prevention does not give much attention to explaining the process of substance addiction. It focuses mainly on the solution: abstinence and abolition.

The *socialization* model focuses on the socialization of the individual. In this model family attitudes and values concerning substance use are considered to be the main determinants of the alcohol use of family members.

The *public health* model of prevention recognizes that problems associated with substance use are due to an unhealthy dynamic between the host (drinker), the agent (substance), and the environment. This model seems somewhat behaviorist in its view of problematic substance use. Its application to prevention suggests three possible areas for focused change to reduce or eliminate the problems associated with use: (1) change the host behavior (either reduce substance use or alter problematic behavior associated with use), (2) control access to the agent (a personalized prohibition of use as in the case of parole or probation limitation), or (3) construct the environment to limit problems associated with contact with the substance (designated driver or other harm reduction programs).

The *distribution of consumption* model of prevention is aimed at stabilizing and reducing per capita consumption through public policy initiatives. Examples of these initiatives include setting minimum drinking age requirements and anti-incentive taxes on specific products aimed at reducing consumption.

The final model of substance abuse prevention which shall be the main focus of this present work is the *sociocultural* model. This model explains substance use behavior based on social class, gender, geography, race and aspects of culture such as social norms, attitudes, religious beliefs, and acculturation. In short, this model analyzes substance use in terms of its dynamic interactions with cultural beliefs, values, traditions, and experiences. In speaking of this model Wright and Watts (1985) write:

> *Some proponents of the socio-cultural model believe that alcoholism prevention measures must modify and/or eradicate patterns of belief and behavior about alcohol and its use, and oppressive and hostile systematic arrangement.* (p.xiii)

This sociocultural model is used to describe the differences in substance use that exists between various cultural groups.

As early as the mid-1940's researchers have been documenting ethnic diversity of drinking patterns. Though these studies have focused mainly on white ethnic Americans (Jewish, Irish, Swedish, and English), they clearly identify differing patterns of drinking across cultures (Greeley, McCready & Theisen, 1980). These studies have led to a socialization model of understanding addictions. This model clearly calls for a culturally specific approach to substance abuse intervention. Greeley, et al clearly state this in the conclusion of their text as they refer to ...

> ... *the extraordinary importance of our findings for the helping professionals. We candidly believe that it would be most unwise to refer a problem drinker to a helping professional who was not sensitive to the kind of diversity we have reported. One cannot, for example, treat an Irish alcoholic like a Jewish alcoholic or an Italian alcoholic, and one cannot even treat an Irish woman alcoholic like an Irish man alcoholic; to do so risks making tragic mistakes in understanding the dynamics of the person's problem.* (p.96)

The recognition of cultural difference in patterns of addictions has not been limited to the above mentioned white ethnic groups. There is a growing body of scholarship related to culturally specific practice in addictions. Examples of such targeted scholarship were presented at the *Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups* at the Atlantic Union College in Massachusetts in March of 1989. At this meeting numerous papers were presented detailing strategies for addictions treatment with Latino and Hispanic Americans (Szapocznick, 1989, March; Amaro, 1989, March), African Americans (Baker, 1989, March; Bell, 1989, March), Portuguese Americans (Moura, 1989, March), Native Americans (Crawford, 1989, March), and women (Derman, 1989, March). Also included were sessions aimed at the generic skills of cultural competence needed to treat individuals in a culturally appropriate manner (Guzman, 1989, March). That such a conference drew speakers

and attendants from across North America is evidence of the interest and credibility of the sociocultural model of addiction.

Empirical Justification For Culturally Relevant Programs

In spite of our knowledge of cultural diversity in issues of drug use, we would argue that the majority of drug prevention programs are designed to be generic in nature and target entire school populations. As well, the majority of research testing the effects of drug prevention programming has been conducted with predominantly white, middle class populations (Botvin, Schinke, Epstein & Diaz, 1994).

A number of researchers in the field of drug prevention have called for culture specific programming (Winick, 1985; Brown, 1993; Catalano et al, 1993; & Segal, 1995). Charles Winick states "what is needed is targeting...of groups which are identifiable and reachable by programs created specifically for them", and further states "not only the goals but also the techniques and modalities employed must be geared to the target population" (Winick, 1985, pp. 528-529). Brown and Alterman (1992), in their article on special populations, states "interventions designed to reach African American youth might have to be tailored to the beliefs, percepts, and needs of these individuals" (Brown, 1992, p. 864). Another author (Segal, 1995) concluded that "If prevention programs are to succeed, they should be based on understanding the relationship between drug taking behavior and the interpersonal, familial, cultural, community and other sociocultural factors that exist within a target population" (Segal, 1995, p. 141).

Within the field of drug prevention, research has only recently begun to test the actual effectiveness of culture-specific programs. Botvin, Schinke, Epstein, Diaz, and Botvin (1995), in a two year follow up study addressing this issue, state "no one has compared a culturally focused prevention program with a generic skills prevention program" (Botvin et al, 1995, pg. 185). This aforementioned follow-up study was designed to address this gap. Botvin et al's (1995) study involved 456 seventh-grade to ninth-grade inner city minority students. Students were matched demographically and assigned to either a generic skills intervention (GSI) condition, a culturally

focused intervention (CFI) condition, or an information-only control (IC) condition. The CFI condition was specifically designed for minority students and employed multicultural myths, contemporary storytelling, peer leaders, video, and intervention providers of the same ethnic background as the participants. Results of this study showed significantly less current use of alcohol, less behavioral intentions to drink beer or wine, and lower risk taking scores for students in the CFI condition as compared with students in the GSI or IC conditions.

In a larger study conducted by Graham, Johnson, Hansen, Flay, Phil and Gee (1990), three seventh-grade cohorts (N= 5,070) were assessed to test the effects of two social psychology-based drug prevention programs and control. One program focused on social skills for resisting drugs, the other on personal decision making, values clarification, and stress management. Graham et al (1990) found significant prevention effects for Asians, non-significant positive effects for Blacks and Hispanics, while no effects were evident among caucasians. Again this underscores the point that culture plays some role in mediating the effects of prevention programming.

The importance of implementing culturally-specific programming is also evidenced when we look at the research conducted regarding smoking prevention and minorities. It is known that patterns of onset with tobacco use differ between white and Black youth (Catalano et al, 1993; Botvin et al, 1989; & Geronimus et al, 1993) with earlier onset found among whites. Botvin, Batson, Witts-Vitale, Bess, Baker, and Dusenbury (1989) conducted a study to test a smoking prevention program designed specifically for urban Black youth. The curriculum was reviewed by Black researchers, a focus group of Black seventh-graders, and an outside panel of experts experienced in working with Black youth to ensure the material was culturally appropriate and relevant for Black youth. Results show significantly fewer smokers in the treatment group than in the control group during the previous month, and that smoking was reduced by 56% among students in the treatment group. Studies such as this one, though small, show the need for more research into culturally relevant prevention programs.

Geronimus, Neidert, and Bound (1993) found delayed smoking initiation and failure to quit among Black women smokers, and advocated that tobacco prevention and intervention efforts take into account age and race interactions. They state "Given the delayed initiation of smoking among Black women in their 20's and the low propensity of Black female smokers to quit, additional components of an effective anti-tobacco strategy are necessary to target young adults" (Geronimus et al, 1993, p. 1263). This also raises the question as to which protective factors are specific to Blacks in delaying the onset of smoking and if these factors can be reinforced during prevention efforts.

Catalano et al (1993) found lower initiation rates not just for smoking but for all drug use among African American fifth-grade students, and lower self reported intention to use drugs as they reach adulthood, despite the fact the drug-related problems are greater among Blacks as they get older. This study also analyzed risk factors and found that African American fifth-graders were more likely to report engaging in anti-social behavior, having more deviant siblings, and that their parents use proactive family management practices. Again, studies such as this and Geronimus et al's (1993) study with women help illuminate some of the culture-specific factors that can be targeted for future prevention efforts.

An unpublished study (Hebb and Leader, 1997), which reviewed the larger or most commonly used school and community-based drug prevention programs in the Halifax Regional Municipality, concluded that all but one (Bold, Black and Proud - a component of the Nia Centre discussed later in the current paper) were void of culture-specific considerations. This is somewhat disheartening given the large Black population in Nova Scotia.

Similarly, an unpublished review of supplemental drug prevention materials (primarily videos) within various schools in the Halifax Regional Municipality (Loba and Leader, 1997) was conducted. This review found that with regard to culture-specificity, only 3.4% of the 88 videos reviewed took into consideration any kind of cultural perspective as it pertains to drug prevention. The huge majority of all videos attempted to be visibly multicultural, but that was as far as the

issue went. While most persons of color were represented in the videos, minorities usually served the role of background characters. More disturbingly, subtle as well as blatant racial stereotypes were evident in some of the videos (for example, no Black male or female was represented as an expert - i.e., a doctor or psychologist - in any of the videos).

The Nia Centre as Example

It is our view that this virtual absence of culturally-relevant programming for African-Nova Scotian populations is indicative of two problems within the formal organizations and systems responsible for drug abuse prevention. First, there is no recognition or understanding of the cultural differences described in this paper regarding drug issues. Without an awareness of the distinct sociocultural influences on behaviour in this area there would be no reason to acknowledge the need for specialized programming. Second, there is a lack of application of a community development approach or at least a lack of understanding of certain aspects of that philosophy. At its very core, it involves looking and listening for the unique characteristics and dynamics of the population being served so as to ensure relevance in the design and implementation of programs.

In attempting to address this void, the authors were involved in the development of the program which is presented here as a model. The Nia Centre (Nia is one of the seven principles of Kwanza, and refers to "Purpose") is an Afrocentric drug prevention program established in 1993 by the Halifax Regional Drug Prevention Network (then called The Mayor's Task Force On Drugs).

The development process took nearly two years, and followed a community development approach. It involved an extensive process of community meetings, surveys, focus groups, and literally dozens of drafts and rewrites of the program design. The final document was therefore created by more than fifty people who lived or worked within the Black community, and particularly in the inner-city area. At the end of that process, the Drug Prevention Network was fortunate to receive three year funding from Canada's Drug Strategy for this program.

Program Components

Youth Development: The Nia Centre ran an Afrocentric drug prevention program for targeted high risk youth. The youth themselves named the program *Black, Bold, & Proud.* The program's design and delivery were as follows:

Afrocentric Curriculum - the *Growing Up Black and Proud* curriculum developed by Peter Bell (1992) was used as the core content of this program. Some adaptations were made (i.e., adding or omitting sections, changing terminology, etc.) to make it more relevant to our local African-Nova Scotian community and its particular prevention needs and goals, and to add more skills-focused learning (see *Skills-Based* section below). In this context, the youth worked on developing a greater depth of knowledge of their African heritage and culture. In addition they analyzed the nature, prevalence, and effect of racism in their community and developed skills for combatting same. All aspects of this program were developed in a highly relevant way which was informed by nearly 400 years of systematically engendered pathological connection between African culture and substance use. The one note of disappointment and caution we must make regarding the curriculum is that it was never piloted and evaluated for actual effectiveness by its creator, or by its distributor (Johnson Institute)*.

Inter-Active Small Group - this was viewed by staff and advisors to the program as a culturally appropriate format. As well, recent research by Tobler (1993) indicates that there may be some advantage to this approach in terms of effectiveness.

---

* Telephone inquiries were made with both the Johnson Institute and with Peter Bell personally.

Gender-Based - the program is run in sex-segregated groups. This helps reduce distraction and allows the program to better address the issues of gender which have impact on drug use behaviour. There is a growing body of research supporting the effectiveness of such gender-based programing (Bahr, Marcos, & Maughan, 1995; Beck, Thombs, Mahoney, & Fingar, 1995; Clayton, 1991; and Graham, Johnson, Hansen, Flay, Phil & Gee, 1990).

Skills-Based - this program while using some affective education, places emphasis on personal and life-skills training which is supported in recent research as an effective approach (Botvin & Botvin, 1992; Tobler, 1993; Dusenbury, 1995).

Formally Recognized - a partnership was worked out with the local school, whereby junior high students participating in this program receive class credit in their PDR course (Personal Development and Relationships). This provides for much needed validation from the formal education system of such African-centered learning.

Community Involvement - upon completion of all sessions, a graduation ceremony is held after which the youth move into the *Community Action* phase. This stage requires them to volunteer their time in some capacity in the community. This may take the form of mentoring for a younger child, or working at the library, the food bank, etc. The youth choose the nature of their involvement, as long as it contributes to the well-being of their community and its members. This is once again promoting traditional African values of collectivism and community responsibility.

Ongoing Reinforcement - after the required community involvement hours are completed, the youth then join an ongoing alumni group which continues to meet and work on issues that reinforce the learning from this program.

Community Development: Based on the community-centered values entrenched in African culture, the second prong of the Nia Centre's focus was on the development of collective action, leadership, and self-determination in the African Nova Scotian community with regard to nurturing the healthy development of the youth. To achieve this end, the Nia Centre recruited community members to form two volunteer community service organizations, one comprised of African Nova Scotian men and the other of African Nova Scotian women. The Nia Centre actively nurtured and supported the development of these groups, they evolved to the point of developing their own missions within the community, their own organizational structures, and their own incorporated identity. Both organizations continue to operate as Brothers Reaching Out Society, and Black Sisters United for Change.

These two organizations, while having developed their own separate missions and plans, have in common a fundamental aspect of their approach. They both operate within an Afrocentric perspective to provide community structure, leadership, and guidance to young African Nova Scotian males and females respectively. They are actively trying to build a healthy community environment for the youth, while serving as mentors and helping to provide the youth with the life-skills necessary for a successful and healthy future.

Program Status

We are certainly not suggesting that this program is the definitive model, or the ultimate prevention tool. In fact, we are aware of specific limitations which we discovered throughout the development of its content and methodology. However, it has been a step in the right direction. As of the time of this publication, the program is being further revised while plans are made for a larger scale pilot and outcome evaluation.

Conclusion

The disease model of chemical addiction is pervasive within the drug abuse field. This model has limitations when trying to explain the complex manifestation of addiction within certain ethno cultural groups. In many of these cases a sociocultural model is more effective. This model has gained great credibility among many professionals working within many non-white groups of North Americans, as well as in empirical prevention research.

An example of sociocultural links in substance use patterns is found within the African American culture. Traditional African boundaries surrounding substance use were clear and effective. The devastating effect of European contact, the ensuing slave trade and other complex cultural and economic issues has created a pathological interconnection between substance abuse and trafficking and the African American community.

A sociocultural approach would deal with these issues in the context of prevention and treatment programs. Unfortunately, in practice this is rarely happening.

We would call upon governments at all levels to embrace the arguments put forward here, and utilize this approach in the formulation of public policy regarding the funding, design, and administration of research and programs in the drug abuse field.

References

Achebe, C. (1958). Things Fall Apart. London: William Heinemann.

Amaro, H. (1989, March). Drug abuse among adolescent mothers a profile of risk and thought of prevention. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Bahr, S.J., Marcos, A. C., and Maughan, S. L. (1995). Family, educational and peer influences on the alcohol use of female and male adolescents. Journal of Studies on Alcohol, 56, 457-469.

Baker, N. (1989, March). Strategies for intervention with Afro-American youths. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Beck, K. H., Thombs, D. L., Mahoney, A., and Fingar, K. M. (1995). Social context and sensation seeking: Gender differences in college student drinking motivations. The International Journal of the Addictions, 30(9), 1101-1115.

Bell, P. (1989, March). Ethnicity and substance abuse intervention strategies with the Black community. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Bell, P. (1992). Cultural Pain and African American: Unspoken Issues in Early Recovery. Centre City, MN: Hazelden.

Bell, P. (1992). Growing Up Black and Proud [multi media]. Minneapolis, MN: Johnson Institute.

Botvin, G. J., and Botvin, M. E. (1992). "School-based and community-based prevention approaches" in Lowinson, J. H., Ruiz, P., Millman, R. B., Langrod, J. G. (Eds.). Substance Abuse: A Comprehensive Textbook, Second Edition, p. 910-926.

Botvin, G. J., Schinke, S. P., Epstein, J. A., Diaz, T., & Botvin, E. M. (1995). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-year follow-up results. Psychology of Addictive Behaviors, 9(3), 183-194.

Botvin, G. J., Batson, H. W., Witts-Vitale, S., Bess, V., Baker, E., & Dusenbury. (1989). A psychosocial approach to smoking prevention for urban Black youth. Public Health Reports, 104(6), 573-582.

Botvin, G. J., Schinke, S. P., Epstein, J. A., & Diaz, T. (1994). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority youths. Psychology of Addictive Behaviors, 8(2), 116-27.

Brown, L. S., & Alterman, A. I. (1992). African Americans. In Lowinson, J. H., Ruis, P., Millman, R. B., & Langrod, J. G. Eds. Substance Abuse A Comprehensive Textbook, Second Edition. Baltimore, MA: Williams & Wilkins.

Brown, L. S. (1993). Alcohol abuse prevention in African-American communities. Journal of the National Medical Association, 85(9), 665-673.

Catalano, R. F., Hawkins, J. D., Krenz, C., Gillmore, M., Morrison, D., Wells, E., & Abbott, R. (1993). Using research to guide culturally appropriate drug abuse prevention. Journal of Consulting and Clinical Psychology, 61(5), 804-811.

Clayton, S. (1991). Gender differences in psychosocial determinants of adolescent smoking. Journal of School Health, 61(3), 115-120.

Crawford, R. (1989, March). Drug and alcoholism counseling and treatment strategies with American Indians. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Derman, L. (1989, March). Women's alcohol and drug intervention treatment. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Dusenbury, L., & Falco, M. (1995). Eleven components of effective drug abuse prevention curricula. Journal of School Health, 65 (10), 420-425.

Geronimus, A. T., Neidert, L. J., & Bound, J. (1993). Age patterns of smoking in US Black and white women of childbearing age. American Journal of Public Health, 83(9), 1258-1264.

Graham, J. W., Johnson, C. A., Hansen, W. B., Flay, B. R., Phil, D., & Gee, M. (1990). Drug use prevention programs, gender and ethnicity: Evaluation of three seventh-grade project SMART cohorts. Preventive Medicine, 19, 305-313.

Greeley, A. M., McCready, W.C., & Theisen, G. (1980). Ethnic Drinking Subcultures. Brooklyn, NY: J.G. Bergin.

Guzman, L. F. (1989, March). Cultural values, acculturation and service delivery. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

James, W. H. & Johnson, S. L. (1996). Doin' Drugs: Pattern of African American Addiction. Austin, TX: University of Texas.

Malcolm (1965). The Autobiography of Malcolm X. New York: Grove.

Mayor's Task Force on Drugs (1993, October). Project Proposal: Uptown Community Futures Program. Proposal submitted to Canada's Drug Strategy for funding consideration.

Medina, E. (Coordinator) (1989, March). Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.*

Moura, J. (1989, March). Substance abuse and cultural specific intervention in different Portuguese speaking populations. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Pittman, B. (1988). AA The Way It Began. Seattle, WA: Glen Abbey.

Segal, B. (1995). Prevention and culture: A theoretical perspective. In Leukefeld, C. G., & Clayton, R. R., Eds. Prevention Practice in Substance Abuse. Binghamton, NY: The Haworth Press, Inc.

Slim, Iceberg (1971). The Naked Soul of Iceberg Slim. Los Angeles: Holloway House.

Slim, Iceberg (1969). Pimp. Los Angeles: Holloway House.

Spraycar, M. (Ed.) (1995). PDR Medical Dictionary (1st Ed.). Montvale, N.J.: Medical Economics.

Szapocznick, J. (1989, March). Breakthroughs in family treatment of problem behavior and drug abusing youths. In E. Medina (Coordinator), Conference on Culturally Sensitive Impact & Substance Abuse: Therapeutic Practice With Multicultural Groups. Symposium sponsored by the Atlantic Union College Department of Sociology/Social Work, South Lancaster, Massachusetts.

Tobler, N. (1992). Drug prevention programs can work: Research findings. Journal of Addictive Diseases, 11(3), 1-28.

Winick, C. (1985). Specific targeting of prevention programs in alcohol and drug dependence. The International Journal of the Addictions, 20(4), 527-533.

Wright, R. & Watts, T.D. (1985). Prevention of Black Alcoholism: Issues and Strategies. Springfield, IL: Charles C. Thomas.

Robert S. Wright, MSW, RSW, has worked in community service, education, corr
health, and child protection. In each role he has sought to model and promote cult
competent practice. He was a contributor to the development of the Nia Centre. F
serves as Casework Supervisor and Clinical Assessor with Family and Children's S
Cumberland County, Nova Scotia.

Todd Leader, BACS, MSc., RSW, is a Registered Social Worker and a Community I
(NSBEP Candidate's Register). He is the Executive Director of the Halifax Regional
Prevention Network (a Municipal initiative; formerly named The Mayor's Task Force
and teaches Psychology for Saint Mary's University in Halifax. He also currently ser
President of the Public Health Association of Nova Scotia, and as Chair of the Addict
Counselling Program for the Nova Scotia Community College. Todd facilitated the c
development and operation of the Nia Centre described here.

Correspondence may be sent to the authors at:

~~Halifax Regional Drug Prevention Network~~
PO Box 1749
Halifax, NS
B3J 3A5

tele. (902) 490-6245
~~fax: (902) 490-6246~~

Robert S. Wright
Family & Children's
of Cumberland
P.O. Box 399
Amherst, N.S.
B4H 3Z5
(902) 667-3336
www.robertswrigl