

Anderson, N., & Kagawa-Singer, M. (1996).
Policy recommendations for ethnic-minority
adolescent health issues: A paradigm shift.
In M. Kagawa-Singer, P. Katz, D. Taylor,
& J. Vanderyn (Eds.), Health issues for
minority adolescents (pp. 217-242). Lincoln,
NE: University of Nebraska Press.

Policy Recommendations for Ethnic-Minority Adolescent Health Issues: A Paradigm Shift

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The present effort on behalf of the youth of our country can be described fairly generously as one of unconcern (Williams & Miller, 1992). A brief overview of some of the statistics reported in this volume shows:

- Adolescents make up the single largest population segment in the United States—31 million;
- 8.3 million youth live below the poverty line;
- one in ten youth in poverty live in inner-city areas that are pervasively poor:
 - greater than 40% are non-Hispanic Whites
 - greater than one third still belong to two-parent families;
- one third of all adolescents in poor and near-poor families in the United States are unprotected by health insurance. The United States and South Africa are the only industrial nations that do not have a national health-insurance plan.

Despite the fact that the federal government spends more than \$11.3 billion annually on programs to benefit youth (see Kemp and Dougherty, in this volume), a young Black man in Harlem has a shorter life expectancy than a young Black man in Ethiopia because of poor health conditions and high-risk behaviors (McCord & Freeman, 1990).

We believe that the general lack of responsiveness to the problems of minority youth can be partially attributed to a dominant monocultural perspective. Therefore, we explore here an alternative multicultural paradigm. Such a paradigm offers greater flexibility and a richer theoretical

rationale with which to develop more effective, culturally responsive programs and research agendas.

Barriers to Quality Health-Care Delivery for Ethnic Teenagers

In the United States today, funding for social and health programs tends to be guided by the reality of "limited good" in funding for social and health programs. Amid seemingly unlimited technical ability, we paradoxically have increasingly unmet needs for basic primary health services such as immunizations, health screening, preventive care, mental-health services, and prenatal care for adolescents. Four major barriers to adequate health care for our youth emerge from the issues covered by the authors in this volume: difficulty with access to health care, a quick-fix public mentality, fragmentation of services, and a lack of cultural responsiveness in the programs and by care providers.

Access. As described by Allen and Mitchell (in this volume), poverty is one of the greatest single health risk factors. Two million adolescents have no health insurance; those youth who are insured are often underinsured. Even those who have apparently adequate coverage are too often unable to obtain care because either facilities are not geographically accessible or there are too few practitioners who accept Medicaid coverage to provide the care.

Short-Term Solutions. Short public attention spans support a single-problem focus with quick effects; this approach, while politically popular, hampers the long-term, intensive efforts required to make a difference. In the last few years, for example, much attention, money, and professional and volunteer effort have been expended on the problems of AIDS and homelessness. Although the problems are growing, the public seems to be disenchanted, less interested, and turning toward the search for more responsive causes. Similarly, since teenage health and social problems appear recalcitrant to single-focus solutions, early public interest seems to be turning into frustration and resignation.

Fragmentation of Available Services. Many agencies and federal programs are directed toward youth welfare, but these agencies compete for the limited

supply of both trained personnel and funds and even duplicate each other's efforts. Consolidation and coordination could vastly improve service delivery. Molly Coye, former director of the California State Department of Health Services, has described how a reconfigured public health-care system requiring relatively minor funding to improve data systems would simplify the complicated bureaucratic web that is supposed to function as a safety net for the indigent and the underinsured.

The problems delineated in earlier chapters are multifactorial and socially contextual. Effective solutions must consider the entire ecosystem within which such behavior occurs as suggested in the chapter by Katz and Taylor. A holistic approach to understanding, preventing, and treating high-risk behavior is needed rather than the more typical fragmented, symptom-management approach. The design of Hawaii's Native Hawaiian youth program described by Miike (in this volume) exemplifies this approach.

Cultural Responsiveness. Adolescents from all cultures go through comparable physical changes and learn similar developmental tasks. Considerable variation exists, however, between and within cultural groups in defining acceptable group parameters for adolescent behavior, degrees of responsibility that must be assumed, and desired adult roles. To be effective these cultural differences must be incorporated into the design of programs for adolescent health and in the training and practice of adolescent health practitioners.

Cultural responsiveness requires that adolescents be treated differently to achieve fair and equitable outcomes (Konner, 1991); a single design is insufficient. More accurate knowledge about the nature and influence of culture on adolescent behavior would enable us to provide more effective intervention programs.

Adolescence, Culture, and Ethnicity

Culture provides a blueprint that guides our behavior, helps us to determine our values and beliefs, and enables us to evaluate and make sense of our world (Herberg, 1989). Culture passes from the generation of our ancestors to future generations, linking past, present, and future through this heritage (Anderson, 1992a). In this context, *ethnicity* refers to the traditions, values, perceptions, and practices we share through identification

with a group of individuals who have in common a geographic and/or racial origin, a language and dialect, a religious faith, or some combination of these (Spector, 1991). These definitions of culture and ethnicity provide the basis for the subsequent discussion of adolescents who live within two cultures: that of their ethnic group and that of the dominant Western society.

Adolescence is the transition between childhood and adulthood. In many cultures special rites and rituals signal the onset of puberty. These initiation ceremonies mark the beginning of specialized education concerning gender roles, community rules, and adult responsibilities of the group. Initiation rites are not universal, however. Among many ethnic groups, the interval of adolescence holds no special significance apart from growing up and taking on adult roles (Stone & Church, 1975).

In the modern Western world, we have come to expect teenagers to challenge authority and test rules. In mainstream Western society most people do manage to make their way through the perilous teen years and become productive adults. For adolescents who live outside the mainstream as a result of poverty, homelessness, or ethnic-minority status, however, these years often present additional challenges accompanied by deprivation, loneliness, alienation, and hopelessness.

ADOLESCENT GROWTH AND DEVELOPMENT FROM THE WESTERN PERSPECTIVE

The adolescent passage is marked by the biologically universal rapid physical growth of primary and secondary sexual organs, corresponding psychosexual development, and body image changes. This stage is characterized by a pervasive search for identity, expressed in risk taking, limit-challenging behaviors, and increased reliance on peer-group relationships (Elliott & Feldman, 1990; Schuster & Ashburn, 1980). Western society expects adolescents to adapt to a new body image and new gender roles, become independent financially and emotionally and acquire its adult values and ethics (Erikson, 1968; Havighurst, 1953; Mercer, 1979).

These expectations, and the psychological events associated with adolescent passage, "are not a necessary counterpart of the physical changes of puberty" but rather "a product of an increased delay in assumption of adult responsibilities" in complex mainstream Western society (Stone & Church, 1975, p. 8). Many of these same expectations exist in many less technologically complex societies, but they are condensed into a shorter

time frame. In the industrialized world, with its long educational process required for work preparation, the adolescent passage may last for eight or more years. This fact has led many investigators to subdivide adolescence into early, middle, and late substages, spanning from as early as age 10 to as late as the middle 20s, each with differing characteristics (Elliott & Feldman, 1990). This long interval between the onset of biological maturity and the full assumption of adult roles is relatively recent even in modern Western society (Stone & Church, 1975).

INFLUENCE OF CULTURE ON ADOLESCENT GROWTH AND DEVELOPMENT

Families are the primary source of training in a culture's values and way of life to develop self-confidence and trust. Most ethnic groups, however, define *family* more broadly than the nuclear or extended family definition recognized as the "legitimate" structure in mainstream U.S. culture. For minority teenagers, family tends to be more inclusive and constitutes a major source of strength.

In many traditional Native American tribes, for example, the family constellation was structurally open and included clusters of other family groups in several different households like a small village (Red Horse et al., 1978). Whenever a problem occurred for one family member, a natural network was already in place to help the individual cope with it. If a parent was unable to serve as a caretaker, grandparents, aunts and uncles, and cousins were readily available to carry out the parenting role (Red Horse et al., 1978). Adolescents who had difficulties with their biological parents could seek shelter and advice from other trusted adults. Furthermore, the adolescents themselves often engaged in necessary and valued work within the community.

Compadrazgo, a Filipino coparent ritual kinship or compadre system, is another example of extended ethnic family systems (Affonso, 1978). The network of parents, godparents, and family friends in many Filipino communities is reinforced by shared rituals, gatherings, and celebrations that bring members together. The compadre system provides adolescents with additional caring adults in their communal network and develops expanded kinship ties and reciprocal obligations which help foster adolescent self-esteem (Affonso, 1978). Affonso described her participation in this system: "As I grew older, especially during high school, I became resentful

of my responsibilities to the chickens. I would always have to rush home after school to be sure the chickens were fed. When we had after-school functions, I would run home, feed the chickens, and then run back to school" (Affonso, 1978, p.129). Nevertheless, Affonso appreciated the praise she received and recognized how fulfillment of the needed childhood roles contributed positively to her development.

As Sandra Cisneros has described such roles, "Salvador whose name the teacher cannot remember, is a boy who is no one's friend, runs along somewhere in that vague direction where homes are the color of bad weather, lives behind a raw wood doorway, shakes the sleepy brothers awake, ties their shoes, combs their hair with water . . . Helps his mama, who is busy with the business of the baby" (Cisneros, 1991, p.10). Like Salvador, teenagers are responsible for taking care of younger siblings and do work essential for the economic and social welfare of the family, which contributes to adolescent growth and development (Mead, 1928; Whiting & Whiting, 1975). A sense of community, important work to do, and reciprocal networks of obligation and support all aid healthy transitions from childhood to adulthood.

Initiation rituals associated with puberty also help tie the adolescent to the community. Even when these ceremonies involve pain and humiliation, adolescents anticipate them positively because of the associated community solidarity and assigned status as an adult.

The extended network of ethnic-community ties provides both advantages and disadvantages for teenagers. The Filipino and American Indian kinship systems, and that of Native Hawaiians as described by Miike in this volume, demonstrate some of the advantages. Through consanguinal (blood), affinal (in-law), and compadre (coparent) ties, adolescents receive gifts, advice, love, and concern from many adults besides their biological parents. Thus, they have more alternatives and a greater variety of adult role-modeling behaviors. These advantages are continued after immigration if members of an ethnic group are able to retain their group identity.

The primary disadvantages for ethnic teenagers are discrimination, poverty, isolation, alienation associated with racism, and related sequelae such as mental and physical illness. The words of a 17-year-old Southern Cheyenne boy express the crisis of identity he feels between his native culture and the world he must live in: "I think differently at home. My people

don't think like the white man. For us, things happen when other things happen. I think in two different ways: the Indian way and the white man's way. Sometimes—like when I think that maybe so many bad things have happened to my family because my mother angered a witch—it's like I use white man's thinking, but it's about Indian things. So I wonder just who am I?" (Allen, 1973, p.374).

Many aspects of culture can be lost in the process of acculturation into mainstream society. These losses leave holes in the fabric of everyday family and group life that are poorly filled by the dominant culture. Adolescents become confused if they feel they must choose one or the other. While the implicit message is to relinquish one's ethnic identity and take on that of the standard White culture, complete assimilation is often prevented by discrimination. In a pluralistic society, bi- or multiculturalism should be recognized and fostered for the strengths and options it provides.

The acculturation process in many ethnic families is initiated first among the children and teenagers who must adapt to the expectations and mores of the dominant culture expressed in school rules and in their interactions with teachers and peers. These children often have to lead double lives: one in school and one at home. They frequently speak different languages, eat different foods, and interact with others in radically different ways at home and at school.

American Indian children who were forced to attend federal boarding schools, for example, were forbidden to speak their native language or practice their indigenous religion at these schools. On their return home, these children often had to face ritual cleansing to "rid them of their white man's ways" (Allen, 1973, p.372). The more fully these Plains Indians students learned "White man's ways," the more likely they were to assume an identity that was seen by their tribe as negative and disloyal to their heritage. Thus, they straddled two cultures and were comfortable or welcome in neither, risking "dead-end acculturation without assimilation" (Allen, 1973, pp.372-373).

Other ethnic adolescents face similar dilemmas. Their discomfort or alienation may lead to emotional despair, alcohol and drug use, and even suicide to dull the confusion and pain. These teenagers may need assistance to recognize that the choices are not to live in one culture or another but rather to develop an ability to function effectively in many cultural worlds.

They can learn to be culturally as well as linguistically fluent and enrich their identities as they gain a sense of self-worth through these increased skills.

THEORETICAL APPROACHES TO ADOLESCENCE

Policies that have guided development of the health-care infrastructure in the United States are largely based on beliefs and premises originating from restrictive or outdated theories that fail to value the importance of ethnic identity.

Psychoanalytic Theory. Early psychological theories of adolescence were greatly influenced by Freud, whose psychoanalytic theory posited that the adolescent passage (the genital stage, begun at puberty) revived the issues of infantile sexuality and eventually resolved the Oedipus complex (Blos, 1980; Deutsch, 1944; Freud, 1905/1953). Adolescent problems were thought to arise from an inability to find socially acceptable outlets for their sexual drives (Rappaport, 1972).

Developmental and Social Theories. Many clinicians and theorists found that classical psychoanalytic theory did not adequately explain many aspects of teenage behavior. Consequently, subsequent theories moved in directions more developmental or sociological.

Erikson (1968), in a more psychosocial version of psychoanalytic theory, suggested that healthy teenagers successfully pass through adolescence when they achieve a solid sense of identity, of who they are in relationship to their world. Levine (1980) claimed that two basic psychosocial needs dominate adolescence: the need for a belief system, an intense belief in something relevant, and the need for a sense of belonging, a sense of community.

Jessor and Jessor (1977) developed a model to explain adolescent problem behavior using an approach that linked social, developmental, and personality psychology. This theory was grounded in the belief that problem behavior is an expression of social-psychological relationships between three systems: the personality system, the perceived environment system, and the behavior system. According to this model, behavior is connected with "its conceptual determinants in the personality and the perceived environment," and problem behavior is viewed as an expression of "opposition to conventional society" (Jessor & Jessor, 1977, p. 37).

Social-learning theories posited that teenagers learned socially acceptable and age-appropriate behaviors through a modeling process (Bandura, 1977). Mastering these tasks results in the recognition of personal efficacy (Bandura, 1977). Schinke and Gilchrist (1984) extrapolated from this theoretical base to propose that life-skills counseling that helped young people solve problems increased their sense of social and personal competence. Their active intervention approach incorporated six components: age-appropriate and topic-relevant information; problem-solving strategies and practice; development of the inner voice for positive self-instruction; practice with adaptive coping strategies; choice of effective personal verbal and nonverbal communication style; and building of an interpersonal support system (Schinke, Botvin, & Orlandi, 1991; Schinke & Gilchrist, 1984). Many current programs for adolescents are based on this approach.

This progression of theories demonstrates an evolution of thinking that focuses on an instructional path to guide adolescent growth and development. Such models reflect the desire of mainstream society to actively predict, direct, and control adolescent behavior. Power and control remain in the hands of adult experts; the positive contributions of diverse ethnic and cultural identity are not actively considered. Instead, ethnic identity is implicitly viewed as a deficiency or barrier by the dominant culture (see Taylor & Katz, in this volume). Underlying these developmental models is the belief that expert knowledge and power can be used to guide and direct the behavior of others.

Theory of Power Utilization. The seminal questions in a multicultural society are these: Who holds the power? How is it used? How is it viewed by those who are manipulated by the agents enacting the power? French and Raven (1968) defined power in terms of influence exerted on an individual by a social agent to effect behavior, attitude, or value change. An agent whose goal is to influence change in another person employs one or more of five power bases: reward power, or positive reinforcement; coercive power, usually associated with the threat of punishment; legitimate power, given as a behavioral prescription through the culture by a trusted agent; expert power, through the specialized knowledge of the agent; and referent power, through identification with a respected agent (French & Raven, 1968).

We argue that the consistent use of coercive power, through the exercise of force and punishment, and expert power, through the use of knowl-

edgeable agents, has dominated the approach to treatment and prevention of adolescent problems in Western society. Referent power, which depends more on mutual respect and participation, is often ignored. The results of emphasis on coercive- and expert-power tactics that exclude minorities from participation in mainstream policy decision making are reported in preceding chapters.

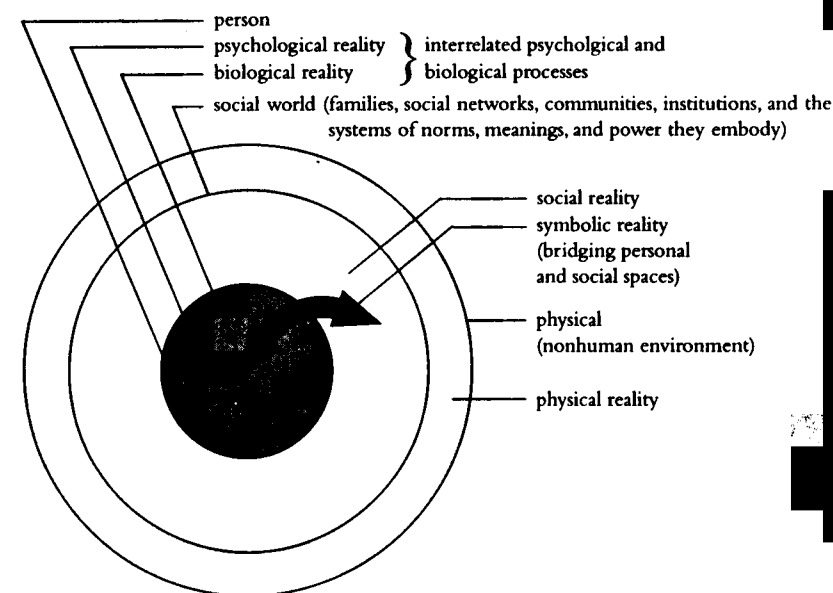
Culture-based Models. Dissatisfaction with the limitations of theories based on the biomedical model has led anthropologists who study health-related phenomena to explore more holistic and culturally sensitive theoretical constructs. Ecological models that combine cultural, environmental, and biological concerns became central to the development of medical anthropology (Alland, 1966; McElroy, 1990; Wellin, 1978; Wiley, 1992).

As McElroy pointed out: "To be truly integrative in design means more than doing a little ethnography as a supplement to collecting biological data. . . . Integrative thinking means *rethinking* basic assumptions, asking new questions, challenging existing theories, and forging new methods. It means moving flexibly between biological and cultural realms in an era that rewards specialization" (McElroy, 1990, p. 244). McElroy described a biocultural model that integrates research methods to focus equally on sociocultural, biological, and environmental data collection and analysis, thus providing a much broader perspective on human health-related behavior.

Kleinman (1980) provided another such approach. The individual is at the center of his models of general and clinical reality. He argued that the health-care delivery system is a system of symbolic meanings that evolve within social institutions and patterns of interpersonal interactions. "In every culture, illness and the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system" (Kleinman, 1980, p. 24).

The nature of these interrelationships is depicted in Figure 8.1. As can be seen, the *person* is located at the center of three concentric spheres of psychological and biological processes. These processes incorporate both *psychological reality* (the inner world of the individual) and *biological reality* (the infrastructure of the organism) (Kleinman, 1980). The *social world* surrounding the person comprises the person's perceived social reality, in-

Figure 8.1. Types of reality

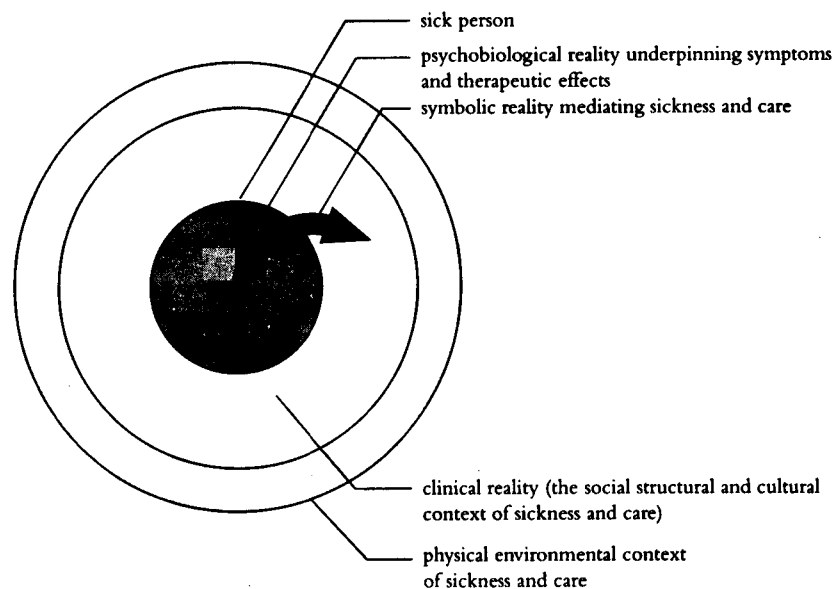


Source: Arthur Kleinman. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry* (p. 106). Berkeley: University of California Press.

cluding families, social networks, communities, institutions, and systems of norms and meanings, as well as the power they generate. Kleinman identified the transactional world as the place where everyday life occurs and social roles receive definition through negotiation and performance. Transactions between the person and the social world occur through the use of recognized symbols or *symbolic reality*, which forms a bridge linking social reality with the psychological and biological reality within the person. The outermost sphere is the *physical environment*, which incorporates *physical reality*. Physical reality refers to the material structures and spaces of the nonhuman, physical environment (Kleinman, 1980).

Kleinman (1980) used a second set of three concentric spheres to explain illness and illness behaviors as depicted in Figure 8.2. The *sick person*, and his or her *psychobiological reality of symptoms*, is at the core surrounded by the *clinical world*. Within this world, *clinical reality* refers to the beliefs, expectations, norms, and behaviors associated with illness and the delivery of health care. Communicative transactions occurring in the clinical world

Figure 8.2. Clinical reality



Source: Arthur Kleinman. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry* (p.106). Berkeley: University of California Press.

constitute symbolic reality and are primarily involved with the mediation of sickness and health care. In this model, the outermost sphere is the *physical environmental context of sickness and care* (Kleinman, 1980).

The Application of Culture Theory. Within biocultural models, such as Kleinman's, the teenager as an individual and as a member of an ethnic group is given a legitimate social position. The perspective of teenagers becomes a central focus. If health practitioners were to view culture and ethnic-group identity as an asset, they could assess adolescent behavior from a positive perspective within the teenage social world; this approach could reduce the need for coercive power and could channel expert power toward more effective collaborative efforts between teenagers and clinicians.

A holistic assessment begins with the teenager's physical and psychological development (Kleinman, 1980). This biological reality of the adolescent's personal inner world interacts with his or her social world, and its significance is filtered through ethnic and cultural symbols.

THE INFLUENCE OF ETHNICITY ON SOCIAL SUPPORT IN ADOLESCENCE

Ethnic kinship patterns and belief systems influence the behaviors of individuals and families during the process of acculturation into the larger society around them, and the manner in which ethnic members seek and give help is often rooted in traditional kinship structure and values, as illustrated by many of the authors in this volume. Social support must be understood within this context (Jacobson, 1987), which implies that the particular meaning of support for both the giver and the receiver and the context in which help is sought and provided may vary from one group to another.

As an example, Sudarkasa (1988) traced African American kinship relationships back to cultural patterns of early African family structure organized around a core consisting of "adult siblings of the same sex or by larger same-sex segments of patri- or matrilineages" (p. 31). In-marrying spouses and children from conjugal relationships formed the outer group. All lived together in a communal compound, and wives and husbands often lived in separate dwellings within the compound. Children, frequently grouped according to same-gender and age mates, were socialized within the extended family. Adolescents had available numerous trusted adults for nurturance and support.

Thus, while Black family structure has changed considerably from the cultural patterns of early African families, "the persistence of some features of African family organization among contemporary Black American families has been documented" (Sudarkasa, 1988, p. 39). During the intervals of slavery and subsequent emancipation, when African families were purposefully separated, the need for ethnic support networks was even greater and resulted in many creative variations of these traditional kinship systems. Stack (1974), for example, documented successful networks of material and emotional support shared among sisters and brothers, as well as extended networks that included neighbors and friends. Although this reliance on the consanguinal rather than the conjugal family unit has been interpreted as unstable by some investigators, others (e.g., Sudarkasa, 1988) regard it as a reflection of kinship traditions and a source of strength.

Regardless of the quality and availability of support at home, teenagers also look to peers for emotional support. Peer-group support may be found at school, within the neighborhood, and in youth gangs. Peer-group sup-

port may be beneficial when freely sought and received or detrimental when it involves coercive power or control.

Teenagers may willingly join a neighborhood youth gang, knowing they must adhere to gang control and surveillance, because the economic and group solidarity benefits outweigh the perceived price. Often the coercive aspects of gang membership become more prominent later. According to Horowitz (1990), there are two primary explanations as to why teenagers join gangs: they make a conscious and rational decision to join (Sanchez-Jankowski, 1991) or are pushed into gangs by their poverty or minority group status (Vigil, 1988). A somewhat different perspective emphasizing the need to escape was offered to one of the authors by a teenager in juvenile detention: "It started out when I was 11 . . . (when I tried) to get away from my problems . . . (by) eating a lot and (drinking) alcohol. I didn't have family love . . . and then time progressed and before I knew it . . . I started gangbanging . . . then I started smoking . . . and experimenting with drugs and stuff . . . (because of the homies) . . . then I ended up (on the street) being a prostitute. You know, it's just like the domino effect . . . it just keeps on going" (Anderson, 1992b).

Thus, social support can be either a positive force for adaptation or a negative force leading to trouble and pain. Regardless of the nature of the support network and the individual teenager's inner strengths, the social, political, and economic policies of the dominant culture still remain.

Overview of Critical Issues for Ethnic Adolescents

HEALTH-RELATED POLITICAL AND ECONOMIC ISSUES

Each of the preceding chapters identifies social, political, and economic forces that are determining factors for the future of today's teenagers. Both material and cultural changes have contributed to increasing problems for U.S. adolescents (Fuchs & Reklis, 1992). Among the indicators of these problems are the nearly tripled rates of suicide and homicide, increased rates of births to unwed mothers, rising poverty rates, tripled rates of child abuse, and lowered proficiency test scores of junior and senior high school students. The number of married women in the labor force has also more than tripled in the last thirty years (Fuchs & Reklis, 1992). This trend, coupled with the paucity of affordable quality day care, leaves many children and adolescents unattended and unguided during the day.

The impact of teenage pregnancy is felt by all but is likely to be particularly difficult for minority teenagers and their families. Most researchers

agree that the consequences of adolescent pregnancy render teenage mothers at increased risk for educational, health, social, and economic problems in the future (Furstenberg, 1976; Hayes, 1987). A recent study reported that 37% of homeless families receiving public assistance in New York City had a baby born before the mother reached 18 (Weitzman, 1989).

Interestingly, the outlook for teenage parents may not be as bleak as these statistics imply. For some ethnic groups, pregnancy at a young age carries no stigma. Continued love and material and emotional support enable some teenage mothers to overcome barriers and manage to become both successful parents and individuals (Furstenberg, Brooks-Gunn, & Morgan, 1987).

Policy Gaps

We submit that the current myopic focus on short-term solutions to the complex problems of adolescent health has a high probability of failure in the long term. Funding priorities are currently directed toward single problems (e.g., teen substance abuse, adolescent pregnancy, and juvenile delinquency). The lack of significant improvement in these problems produces frustration and despair on the part of funding agencies. The result is that poverty and ethnicity are often used as both explanations for problems and justification for failure to intervene with comprehensive prevention and treatment programs. The approach to adolescent high-risk behaviors then becomes punitive (Reuter, 1992). Reuter suggested, for example, that the war on drugs be less "hawk"-like and more "owl"-like by placing major emphasis on prevention and treatment rather than only on tough enforcement (Reuter, 1992).

The present punitive approaches to adolescent high-risk behavior have not led to solutions and may have exacerbated the problems. As suggested by the present authors and the Office of Technology Assessment report on adolescent health (1991a, 1991b, 1991c), longer-range efforts directed to prevention and treatment would have a greater likelihood of saving future tax dollars and lives.

TARGETING CHILDHOOD HEALTH

High-risk adolescent acting-out behaviors do not suddenly emerge with puberty; their antecedents can be seen in childhood. For example, child abuse has been frequently implicated as a primary cause of subsequent run-away, substance-abuse, teen pregnancy, and other high-risk adolescent behaviors (Boyer & Fine, 1992; Dodge, Bates, & Pettit, 1990; Morris & Bi-han, 1991; Polit, White, & Morton, 1990).

The term "child abuse" is generally used to cover a broad age span and range of behaviors—it refers to the physical, emotional, and sexual abuse of youths from infancy through adolescence. Placement of youth in foster care has been a major intervention strategy for abusive families. Issues that arise with foster care, however, present another example where programmatic gaps exist for both these young people and their parents (Hochstadt et al., 1987; Schor, 1989). First, there are too few qualified foster parents. Lack of adequate reimbursement for foster parents and problem complexity explain a large part of the paucity of good quality foster homes (Schor, 1989). Failed placements may result in further abuse and trauma (Molin, 1988; Schor, 1989; Stepleton, 1987; Woolf, 1990). Difficulties with placement are often intensified for adolescents since they often have a longer history in foster or institutional care. Many teenagers respond to continued foster care by running away and thereby become entangled in the juvenile-justice system. And the cycle continues.

RECOMMENDATIONS FOR EARLY INTERVENTION

Early intervention is needed for ethnic families who need assistance in dealing with social, economic, and physical- or mental-health problems and to prevent abuse and homelessness before they occur. The primary target for programmatic and funding efforts should center on establishing a "family friendly" atmosphere in which families can learn coping strategies and develop knowledge about childrens' growth and development.

Prevention of health problems and the empowerment of ethnic teenagers begin with ensuring equal access to educational and employment opportunities. Although strides have been made, we are still a long way from achieving this goal.

A logical starting point would be to provide adequate child care for all working families. This achievable primary intervention strategy would help to avoid some of the family crises that result when overstressed working parents must rely on inadequate or nonexistent care for their children. Impoverished ethnic-minority families currently have the fewest-available quality choices for day care (Hayes, Palmer, & Zaslow, 1990).

Examples of Effective Programs

Effective programs are cost-effective, eliminate or delay the onset of adolescent high-risk behaviors, prevent subsequent illness, and reduce the

negative economic and social consequences of illness for teenagers and their families. Several such programs are worth noting here.

PREVENTION EFFORTS

A well-funded exemplary program is Homebuilders, a project initiated in Tacoma, Washington, that has proven that intensive coordinated help given to families at the time of crisis can prevent foster-care placement (Schorr & Schorr, 1989). Homebuilders provided in-home intensive family therapy and assisted families in repairing their own problems and regaining control of their own lives. While the initial amount expended (\$2,600) for a single family may seem high, it is cheaper than long-term foster care (\$3,600), group care (\$19,500), or psychiatric hospitalization (\$67,500). One year after completion of the Homebuilders program, 90% of those who would have been put in foster homes were still living at home (Schorr & Schorr, 1989). The question is why we continue to resort to costly tertiary interventions when primary prevention programs have proven their cost-effectiveness and their ability to save priceless human lives.

Recent focus on the prevention of adolescent high-risk behavior has resulted in many programs that target preteen and early-adolescent age groups. One such program, Postponing Sexual Involvement, was initiated in Atlanta in 1983 by the Henry W. Grady Memorial Hospital (Howard & McCabe, 1990). This program targeted 13–15-year-old boys and girls (many low-income minority students) with a public-school-based family-planning program. Older teenagers taught the younger ones how to resist peer pressure and postpone sexual involvement.

The results were extremely successful. As the authors noted: "By the end of eighth grade, students who had not participated in the program were as much as five times more likely to have begun having sex than were those who had the program" (Howard & McCabe, 1990). The state of California initiated a statewide program in April 1992 based on this curriculum (Education Now and Babies Later, or Project ENABL).

Another primary prevention program targets preteens (ages 10–13) and their parents. This program, Reaching Adolescents and Parents (RAP), was developed by the American Red Cross and is offered in community- and school-based settings. It includes active participation by parents during some segments of the course. Program goals include teaching about puberty and human reproduction, increasing decision-making and commu-

nication skills, facilitating family communication, and delaying the onset of sexual activity among the preteen program participants (American Red Cross, 1990).

Similar projects, such as DARE (Drug Abuse Resistance Education), target pre- and early-teen groups with programs designed to prevent adolescent substance abuse and gang involvement. One such community-based program, Making the Right Connections (MTRC), sponsored by the Sisters of St. Joseph Ministerial Services, reaches out to children in grades two through eight with an intensive six-week cooperative summer program. Started during the summer of 1989, this program has been successfully conducted in South Central Los Angeles for four years. The curriculum includes conflict resolution, community building, values clarification, gang and drug awareness, and multicultural art activities.

School-based clinics have been effective in numerous states across the country (Dryfoos, 1988; Kirby, Waszak, & Ziegler, 1991). Some school-based clinics have also included a special focus on pregnancy prevention and the prevention of substance abuse, HIV/AIDS, or sexually transmitted diseases. Overall evaluation of the effectiveness of school-based clinics is complicated by the fact that program services, organizational structure, and data-collection methods vary widely among programs (Dryfoos, 1988; Kirby et al., 1991).

The Mysteries Program, begun at a number of middle and secondary schools in the Southern California area, is a program designed to develop character, community, and spirit. It allows students to express personal authenticity and independence and to function cooperatively in the face of competing needs.

The program format is based on the Native American Indian council for problem resolution. Problems presented always relate to adolescence. Three basic rules are followed: speak only in turn, speak briefly, and speak from the heart. The participants are also taught the art of listening, skills for conflict resolution, stress management, group problem solving, and effective communication. Workshops for teachers are being held annually. The program, designed eight years ago, is now conducted regularly in schools all over the globe (Kessler, 1990).

Researchers identified several specific components from a variety of programs that have a positive impact on teenage participants. These components include life-skills training (Schinke & Gilchrist, 1984; Schinke et

al., 1991) peer support and counseling (Rind, 1992), mentoring (Hamburg, 1992; Levine, 1992), and habilitation (providing conditions which encourage learning and responsible behaviors [Morrison, 1990]). Traditional service delivery, self-esteem building, values clarification, and decision-making experience have also been found useful. A number of mediating factors influence program outcomes, including comprehensiveness of the program, a sense of control, a stable family life, intent and realistic potential for attending college, and economic self-sufficiency (Furstenberg et al., 1987; Horwitz et al., 1991; Miller et al., 1992).

Recommended Future Policy

HOLISTIC, CONTEXTUALLY BASED PROGRAMS

The approach advocated in this chapter for policy, program development, and research is an adolescent-centered paradigm that places adolescent development within a social, political, economic, and cultural context and builds on available strengths. Because of its emphasis on prevention, this paradigm, though rarely utilized, would be both psychologically effective and more cost-effective. Cultural responsiveness may also be of particular significance for ethnic teenagers, and its important elements are discussed in the concluding parts of this chapter.

CULTURALLY RESPONSIVE PROGRAMS

Sue (1991) has recommended that culturally responsive programs have four elements: inservice training about culture and health for psychotherapists; more recruiting and training of ethnic health-care practitioners; the establishment of specific ethnic services; and the creation of new, effective therapies and delivery systems.

There is ample evidence that African Americans, American Indians, Asian Pacific Americans, and Latino Americans are severely underrepresented among psychologists, nurses, and physicians (Howard et al., 1986). We need to know how the ethnic match between therapist and client affects outcomes.

Similarly, the outcomes of care in service centers designed and staffed by ethnic members have not been evaluated or compared with mainstream service centers. We do know, however, that, compared with population percentages, Asian Pacific Americans and Latinos have lower use rates for physical- and mental-health services and African Americans have higher use

rates than the national average (Sue, 1977). Paradoxically, even with this higher utilization by African Americans, their health outcomes were as poor or worse than those of the Asian or Latino groups. Services that are effective in countering such negative results remain to be provided on a large-scale basis.

EMPOWERMENT FOR TEENAGERS AND FAMILIES:

PLANNING FOR THE FUTURE

While many good programs have been established, they are often the victim of government and private-agency budgetary axes. Downsizing, restructuring, and streamlining for greater efficiency make sense when resources are limited, but they must be balanced by helping people intervene actively on their own behalf.

Planning interventions that start with and build from the strengths of an individual is an often-recommended cost-effective strategy that is rarely employed. The fundamental shift in approaching adolescent health problems must begin by recasting adolescence in a more positive, less negative light. Such a change would encourage care providers and policymakers to explore alternative intervention strategies using less punitive measures. When teenagers run away from a court-ordered placement, for instance, this behavior is legally classified as a status offense with attendant negative labeling and outcomes. Running away, however, could alternatively be viewed as an adaptive response to abuse and may be the only recourse open to a teenager. This changed perspective would lead to a much different intervention strategy.

Ethnicity often provides a basis for within-group solidarity as well as a history and a blueprint for behavioral expectations. Even when adolescents turn more to peers than parents for social and emotional contact, they still appreciate and frequently restate family values. When teenagers in juvenile detention, for example, were asked how decisions about pregnancies are made, they responded with such statements as "In my family we keep our babies and take care of them" (Anderson, 1990). These teenagers fully expected that their pregnancy would be a family matter and that the family would provide the solutions.

Adolescents throughout the country are demonstrating that they have the courage, strength, and fortitude to rise above the incredible odds of poverty, violence, abuse, abandonment, discrimination, and failed family resources, and to survive in an alien world. Mainstream and corporate

America may not always approve of the nature of some routes to adolescent survival, but survival it is. If we want them to survive in more acceptable ways, then we must provide the resources for them to do so. Even more important, we must find ways to use their survival skills to good purpose and help teens direct their innate strengths toward productive and effective outcomes.

One of our best resources for helping adolescents is the power of the person. Teenagers look to parents and other significant adults for guidance. The teenagers Anderson works with in juvenile detention are searching for adult role models they can respect, those who offer honest respect to them, listen, and understand. During focus group discussions about decisions concerning substance use or abuse among detained teenagers, conversation often centers on prevention and treatment programs (Anderson, 1992b). The teenagers frequently commented that good programs were led by adults who "really understand and listen and try to help us" (Anderson, 1992b) and that "adults say we should give them respect (as their elders), but they don't respect us; they treat us like criminals, they call us criminals" (Anderson, 1990).

For many reasons, it is difficult for many adults to really listen to and respect teenagers. In many cities and villages, alienated teenagers have become the adversaries of frightened adults. Fear has clouded our vision.

Programs serving adolescents need to increase input from teenagers themselves. When agencies or organizations attempt to institute change based on their own perceptions without eliciting the teenagers' perceptions and goals and involving them in the design and implementation of the program, behavior change rarely happens. Instead, the long-range impact may result in increased mistrust for mainstream efforts by adolescents.

Referent power, according to French and Raven (1968), is based on the identification the individual has with the agent of social change and on the quality of their relationship. Respecting relationships are built through active involvement and participation where the individual and the change agent are equal partners in a joint endeavor.

Teenagers thrive, learn, grow, and develop new skills and understanding when they are given the opportunity to participate in planning and enacting new programs. The reason peer counselors are such effective change agents is because of their shared worldview and team approach. Adolescents can and should be trusted to work effectively on their own behalf, al-

though they are typically not consulted by policymakers. We can no longer afford to continue making this costly error. Teenagers and their families deserve to participate in charting their future.

We can also no longer procrastinate in initiating much-needed policy and programmatic changes. The physical- and mental-health needs of minority adolescents are urgent. As Konner (1991) poignantly noted:

Adolescence [is] a tumultuous phase of childhood with a sense of paradox and hope. . . . Adolescents are facing the fact that we will not take care of them always, and they know that taking care of themselves will involve hard work and hard choices. Understandably, they resent this. Yet somehow, most children sail the rough seas of adolescence without running aground or going under. With a steady wind behind them in the form of a nurturing childhood, and some adult help in charting a safe course through the teenage years, only a small minority should founder. But this sea is unforgiving and the dangers are grave ones; we are losing far too many as it is and we need to become more serious about preventing those losses (p. 389).

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