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Examining counseling strategies for African American adolescent crack abusers

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Abstract

The author of this paper has addressed the significance of the development of treatment strategies to implement with African American adolescent crack addicts. An integral basis for tailoring culturally specific treatment approaches for African American adolescents relates to the unique circumstances, which may promote more extensive crack abuse by this group. Depression was the difficulty which the author chose to focus upon. Several different methods of helping these adolescents are discussed. The intervention strategies which show promise in helping African American adolescent crack addicts include: (a) Interpersonal Therapy; (b) psycho-educational programs; (c) involvement of family members in treatment; (d) use of medication; (e) family therapy; and (f) developing alternate coping strategies. Lastly the attitude of the therapist appears to be important in addressing the multicultural issues of this special population.

EXAMINING COUNSELING STRATEGIES FOR AFRICAN AMERICAN ADOLESCENT CRACK ABUSERS

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Crack cocaine use is one of the most common practices of cocaine ingestion by African American users (Wallace, 1991). Cocaine is derived from the plant Erythoxylum Coca which is grown in South America. The white crystalline powder which is extracted from coca leaves was initially used to treat a variety of illnesses and was even used by Sigmund Freud and promoted in his 1884 paper, "On Coca" (Wallace, 1991). In 1974, cocaine users began to "free-base" or smoke the active ingredient in a small pipe. Smoking the cocaine was discovered to produce a more potent "rush," a more intense euphoria, and a more powerful high than inhaling cocaine. Crack cocaine is the "precooked" free-base or smokable constituate of cocaine (Wallace, 1991).

Many African American crack abusers are adolescents. Data indicates that African American adolescents who use illegal substances primarily abuse crack cocaine (Cristoph & Sigueland, 1996). Counseling programs which treat African American adolescents may benefit from incorporating culturally sensitive treatment interventions.

It has been postulated that African Americans and other people of non-White cultures may experience different psychosocial characteristics and functioning from Caucasian people (Wallace, 1991). This suggests that there are culturally specific factors which tend to prompt African American adolescents into using crack. Treatment strategies which are sensitive to African Americans may be more successful than treatment programs that are not culturally sensitive.

It may be useful for therapists to understand some of the problems faced by African American adolescents who ultimately abuse crack. Treatment strategies can be developed to explore the underlying forces, which influence some African American

adolescent clients to be vulnerable to crack abuse. Adolescents who are affected by crack addiction pose immense challenges for the school systems, the social welfare systems, and the family systems with which they interface on a daily basis. Mental health counselors can prepare themselves to develop intervention strategies based upon background knowledge of the physiological and psychological effects of crack cocaine to effectively treat these adolescents.

This paper will address the significance of the development of treatment strategies to implement with African American adolescent crack addicts. In order to help readers understand the urgency of the need to develop culturally sensitive treatment approaches for African American adolescents, the author will explore the background of crack addiction among African American adolescents. The author will also review treatment interventions, which will include non-culturally sensitive interventions, related to provisions for detoxification, withdrawal, cravings, and relapse prevention. Use of antidepressant drugs and other drugs will be explored to describe their usefulness in helping African American adolescent crack addicts to remain in treatment and to withstand the uncomfortable effects of crack withdrawal. Even though this information could also relate to non-African American adolescents, the focus of this research will be on African American adolescents.

Definition of Culturally Sensitive Treatment

The definition of culturally appropriate service delivery has only recently received critical attention (Hays, 1996; Marin, 1993; Rogler, Malgady, Costantino, & Blumental, 1987; Zayas, Torres, Malcom, & DesRosiers, 1996). It should be pointed out that

cultural sensitivity is a necessary condition for culturally appropriate service delivery. According to Marin (1993), cultural appropriateness in service delivery requires that interventions be based on the cultural values of the target culture; that the strategies of intervention be consistent with the attitudes, expectations, and norms of the target culture; and that the components of the strategies reflect behavioral preferences and expectations of the members of the target culture.

The approach to culture involves identification of the culture, its elements, and cultural training as essential to the practice of clinical psychology (Linton, 1945). A universal definition of culture is unavailable. Linton (1945) referred to culture as "the configuration of learned behavior and results of behavior whose component elements are shared and transmitted by the members of a particular society" (p. 32). He identified overt and covert aspects of culture. The overt aspect related to the concrete and the tangible (e.g. the material products of industry), whereas the covert aspect reflected the psychological phenomena of knowledge, attitudes, and values. Culture has similarly been defined by Triandis (1990) as "the human-made part of the environment" (p. 36). Triandis described two cultural elements: the objective (e.g., bridges) and the subjective (e.g.. listed beliefs, attitudes, norms, roles, and values).

Background Information on Crack Addiction

One of the possible underlying reasons that has influenced some adolescents to use drugs such as crack is their initial use of use of marijuana and alcohol (Kreek, 1996). Some adolescents merely graduate to the use of crack primarily as a way of "sampling"

the drug. They often are naïve to the addictive effect of crack and are unaware that they may have little success in avoiding repeated use of crack.

Crack enters the blood stream and goes into the brain faster than any other drug. Once the cocaine enters the brain's pleasure zone or reward center where it is released, the individual feels an euphoric rush. After approximately several hours, the euphoric feeling subsides but the brain's pleasure center continues to crave the euphoric sensation (Kreek, 1996). Once an adolescent uses crack for the first time, he or she experiences a "rush" or release of dopamine, a neurotransmitter, which causes such an immense feeling of euphoria that the individual will stop short of nothing to obtain that same high repeatedly. One adolescent explained how he felt powerful and sexy while using crack, saying "I felt like I was the coolest cat that ever lived. I felt like I could make love to many women because I had the energy and drive when I was high" (Anonymous Client, 1984). This information hints at the notion that there may be biological factors taking place in the body, which render it dependent on ingestion of more crack.

Some adolescents claim that their sheer physical strength is enhanced when using crack. In actuality, crack use deteriorates the adolescents' immune system (Wallace, 1991) as opposed to improving it. Often, these teens do not obtain enough sleep to nurture their bodies, and the crack wears the body's defense down until the body cannot fight off infections and diseases such as meningitis.

One of the most horrible features of the crack user's craving for the drug relates to the continual craving despite the crack user's receipt of punishment, which might include incarceration, loss of children, loss of relationships, loss of employment, etc. One

particular study on crack-affected rats examined the rats' desire to ingest crack after receiving a negative reinforcer such an electrical shock (Van Wormer, 1995). Despite the fact that the rats learned that they would receive an electrical shock if they touched the lever which would give them more crack, this punishment did not alter the rats' behaviors which involved ingesting as much crack as possible. The rats continued to ingest more and more crack until they eventually died.

Wallace, (1991) suggested that one of the factors that makes crack so addictive is the intense high or rush felt by users. The author of this study suggested that crack addicts really never experience the same intense rush that they experienced when they first used crack. Although they will yearn for the return of the intensity of their first high, crack users do not reexperience the duplication of this first time event, however they attempt to achieve this sensation (Wallace, 1991). Although the goal of adolescent crack users is to obtain the rush again and again, there appears to be culturally specific differences in the manner in which these individuals obtain crack.

When they run out of money to buy crack, adolescents often resort to crimes such as misdemeanors, which often include stealing from their family and others. Some adolescents will pawn stolen items to obtain cash to purchase more crack. It was noted in one particular study on the effects of crack (Child Welfare League, 1990) that a sixteen year girl became a prostitute to pay for her crack by having sex with any person who came into the crack house. One man paid the man who owned the crack house to engage in some sex act with the adolescent girl who was high when she performed the sex acts (Child Welfare League, 1990). There is a high probability that no protection was used

by this adolescent, and therefore she was also putting herself at risk for developing AIDS or some other sexually transmitted disease.

In one study of drug users in the midwest states, it was discovered that African Americans used crack more on a daily basis than other ethnic groups in the study (Siegal, Carlson, Wang, Falck, Stephens, & Nelson, 1994). Twenty one percent of the African Americans of the study used crack as compared to the 7.6 % of Whites who reported using crack in the study. The study also provided information which showed that the African American adolescent began to use crack at an earlier age than White adolescent users. This information is helpful in understanding the significance of the problem in that treatment programs must acknowledge that the African American patients may require interventions which target a more frequent and longer duration of usage. The study also highlighted the prevalence of crack within demographic areas such as lower socioeconomic sections of cities. The African American clients also were retained in treatment for a lesser amount of time than the White clients were (Carlson et al., 1994).

Another study compared gender differences among female and male African American adolescent crack users in the amount of time that they were retained in treatment. The findings of this study indicated that the female and male African American clients used crack with similar frequency (Lunday, Gottheril, Serota, Weinstein, & Sterling, 1995). There were no significant differences in their usage that was recorded within the first thirty days of treatment. Males were noted to have encountered more arrests than the females and were more likely to have been referred to treatment by probation officers or parole officers. It is suggested that treatment

interventions with this population should focus upon the males' involvement in the criminal justice system.

Prostitution is another form of an illegal means to obtain crack. One particular study of female crack users, which included both teens and adults, uncovered that many of the subjects reported prostitution as a means for obtaining money for their drug use (Muller & Boyle, 1996). By engaging in unprotected sex, these individuals were at risk for contracting the HIV virus, which causes AIDS. Other studies indicated that these adolescents do not use safe sex practices such as using a condom, especially with partners whom they know quite well. Additionally, the females in this study often made a distinction between the males that they knew and the males that did not know when deciding to use condoms or not. At times, the strangers were requested to wear condoms, while the males the females knew were not asked to use protection during sexual encounters. Often the prostitutes would not charge for sex with the males they considered friends. However, an exchange of crack would often compensate for the sex (Muller & Boyle, 1996).

There are other criminal means in which adolescents can obtain or deal crack besides engaging in prostitution. Some adolescents deliver crack for adult drug dealers for a salary that often exceeds the parents' income (Johnson, Golub, & Fagan, 1995). Another crack job is looking out for the police so that the drug dealers can be alerted when police are approaching the crack activity. Because these illegal activities provide such large incomes, many adolescents continue to involve themselves with the crack enterprise to live the long desired lifestyle that they often see on television.

In another study, Fagan and Chin (1991) examined the manner in which inner city African American youth are initiated into using to further investigate how they obtain crack. These authors revealed that youth were initiated into use of crack by more experienced users which is the common practice of heroin users. The authors of this study also discovered that African American youth used other gateway drugs prior to their initiation into crack use. The most common drug used by these youth was marijuana.

In examining the manner in which African American youth are initiated into crack use, Fagan & Chin (1991) identified an intricate socialization pattern. Within this process, older, more experienced peers or relatives mentor African American teens into using crack in most cases. These mentors will often advise the youth in ways to enhance their high, how much crack to use to obtain a desired effect, and finally they learn the definitions and purposes of various drugs. In other words, African American adolescents undergo a learning process for use of crack.

When asked to explain the circumstances that contributed to their first use of crack, the African American teens responded to the following statements (Fagan & Chin, 1991, p. 328):

(1.). I was curious. (2.) Friend urged me. (3.) Dealer urged me.

(4.) Family urged me. (5.) Avoid needles. (6.). Better high.

(7.) I was depressed. (8.) Financial need. (9.) Emotional need.

Of the choices listed, 68 % of the African American teens in this study selected, (1.) "I was curious." Forty four percent of the African American teens selected the

choice of (2.) "Friend urged me." The significance of these findings suggests that treatment interventions be tailored to minimize curiosity about crack and to assist African American youth to resist to the temptations of their friends, mentors, and relatives who try to socialize them into using crack (Fagan & Chin, 1991, p. 328).

Authors of one particular study looked at the potential of African American teens who used marijuana to graduate to the use of crack and other hard drugs (Epstein, Botvin, Diaz, & Toth, 1995) to explore how these youth obtain crack. The authors hypothesized that teens that had developed strong social, communication, and assertiveness skills could protect themselves from drug use. They further suggested that teens who had positive attitudes towards drug use and lack of knowledge about drugs had an increased risk of drug use. It was determined that individuals who received low grades had more than double the odds of intending to use crack within the next year as opposed to individuals receiving higher grades.

The other significant predictor was self-efficacy. Individuals with low self-efficacy had more than double the odds of indicating that they intended to use crack within the next year than those individuals with high self-efficacy scores (defined as the belief that goals can be achieved through personal effort) (Epstein et al., 1995).

Another finding of this study revealed that role models were important influences which determined the use or nonuse of marijuana. If the teens' most admired role model did not use marijuana, this had a negative impact upon whether the teen initiated use of marijuana. If the most admired role model used marijuana, the teen was predicted to use marijuana in the following year.

Several of the females in the study by Muller and Boyle (1996) explained a practice referred to as "freaking and geaking" (p. 38), which is an ethnic term used by persons of the African American culture. These females defined "freaking" as sexual activity and "geaking" as getting high and still wanting more drugs. The process of freaking and geaking fulfilled social and emotional needs, as well as providing a way to obtain drugs. Many of the females in this study participated in unusual sexual activities or whatever the males requested in exchange for crack. What resulted was a social mix of people exchanging sex and using drugs in a casual way. One particular participant in this study explained how sex and crack use were intermixed:

> We all were in the room and this guy came in with some dope (crack). So we went into the bathroom to cut it up. He asked me, "Who is the bitch with the green pants?" I said, "I don't even know her, she came her with X." So he said, "Go tell her I want to do something with her." I wouldn't tell her nothing. I just say he want to talk with her in the bathroom. She was one of the ones who said she wouldn't do that, but I knew the guy, right. She stayed in the bathroom and I could hear him say, "Look bitch, if you ain't going to do nothin, you can get out. Don't you want this crack?" She ended up doing it. (Muller & Boyle, 1996, p.40)

These relationships were important to the females in this study because they had learned that sex enabled them to maintain intimate relationships with men who could help them financially or who could provide them with drugs (Muller & Boyle, 1996). Asking a partner to use a condom would endanger the relationship or "start trouble." This information reflected the high level of a misunderstanding

about how these women could prevent pregnancy or prevent contracting a venereal disease (Muller & Boyle, 1996).

Treatment strategies, then, must assist these women in learning how to satisfy their own emotional needs without engaging in freaking and geaking with males. This process of maintaining these relationships with males is a cultural theme prevalent in many African American communities (Muller & Boyle, 1996). Until these female crack users can learn to satisfy their own emotional needs without involvement in these type of relationships with males, convincing them to protect themselves from HIV by use of condoms as well as reducing their crack use may be unsuccessful. Therefore, the primary finding of this study suggested that these poor African American adolescent females could benefit from acquiring personal empowerment skills in order to recognize the benefit of condom use and to reject the notion of allowing themselves to be used sexually in order to obtain crack.

One study of African American adolescent females indicated that they ignored their health and medical needs due to their crack and other drug abuse (Curtiss, Lenz, & Frei, 1993). Of the 252 African American female subjects within this study, 72% identified crack cocaine as their drug of choice. Many of these females suffered from untreated sexually transmitted diseases, dental problems, skin problems including lice, and nutritional problems upon their admission into this inpatient program (Curtiss, Lenz, & Frei, 1993).

This study is significant because it addresses some of the specific concerns of African Americans female adolescent crack addicts. Counselors can begin to explore

some the ways in which these adolescents may have faulty thinking patterns which could possibly contribute to their feelings of depression (Vernon, 1989). For example, within one drug treatment center, an African American adolescent provided a scenario of her family life which involved her receiving constant verbal and physical abuse from her mother who continued to belittle her because she had extremely dark skin (Child Welfare League of America, 1990). This adolescent girl began to internalize her mother's rejection and concluded that she needed something to help her to feel good because she received no nurturance from her mother. She ultimately became addicted to the euphoric effects of crack cocaine.

Adolescents who have unprotected sex while high on crack (or for the purpose of buying more crack) often deliver crack-affected babies. These babies frequently require specialized neonatal services because of the problems they incur as a result of the mother using crack during her pregnancy. The cost of taking care of one crack-affected baby amounts to thousands of dollars, as they require postnatal care in intensive care units (Child Welfare League, 1990). Often the mother is not employed and must rely on Aid to Families with Dependent Children (AFDC), or a similar government program, and Medicaid to supply the family's income and medical care insurance.

Not only do these babies suffer at birth, they also tend to experience behavioral and cognitive delays in school. Crack-affected babies have short attention spans. They may engage in rocking, banging their heads, acquiring low performance scores, and reflecting low frustration tolerance (Odom-Winn & Dunagan, 1991).

Often the grandparents of the crack-affected babies take on the responsibility of caring for them because the crack-addicted teen mom has lost custody of them due to neglect or ineffective parenting (Child Welfare League, 1990). One study (Levy & Rutter, 1992) concluded that by using crack, many adolescents would ultimately speed up the onset of their labor, which means that these pregnant teens often deliver their babies prematurely. Sometimes the babies can suffer horrible birth defects, which include small heads and small brains, testicles failing to descend, and the penis open rather than covered with a shaft (Levy & Rutter, 1992).

Because many adolescent crack users who are also pregnant do not seek prenatal care until they deliver their babies, most of the damage is done to the unborn baby. The aim of many public health agencies is to provide treatment to the mother as soon as possible to help her to overcome her addiction to crack (Levy & Rutter, 1992). Many of these adolescent mothers lose custody of their babies shortly after they deliver them because the babies are placed in foster homes while the adolescent undergoes drug treatment. The goal of many child welfare systems is to rehabilitate the mother, if possible, so that the child can eventually be reunited with her (Levy & Rutter, 1992).

Mental Health Treatment Approaches for African American Adolescent Crack Addicts

Mental Health treatment for crack addicted adolescents must include education, prevention, and counseling (Pagliaro & Pagliaro, 1996). When working with African American adolescents who are addicted to crack cocaine, it is essential to provide culturally sensitive interventions to restore them to health (Raphael, 1996). Although these adolescents may experience many problems, the one that seems most likely to be

helped by mental health professionals is depression, therefore this discussion will focus upon depression. One of the first steps of outpatient counseling is to assess the client. An assessment method which as been shown to be effective in helping these adolescents is to assess for symptoms of depression (Pagliaro & Pagliaro, 1996). Often, these depressive symptoms may be the result of the adolescent's experiences within a dysfunctional family, difficulties due to low self-esteem, or the results of sexual abuse. Several different methods of helping these adolescents are described in the following sections of this paper. These intervention strategies include: (a) Interpersonal Therapy, (b) psychoeducation programs, (c) assessment for depression, (d) involvement of family members in treatment, (e) use of medication, (f) family therapy, and (g) developing alternate coping strategies.

Interpersonal Therapy

Following a successful detoxification, the African American adolescent may benefit from outpatient counseling (Pagliaro & Pagliaro, 1996). Interpersonal therapy (IPT), a form of outpatient counseling, is based on the premise that depression occurs in an interpersonal context (Weissman & Klerman, 1990). Practitioners of this orientation do not deny that genetic predisposition and biological symptoms exist. The emphasis of IPT, however, is on the contextual aspects of depression. The goal of this therapy is to alleviate symptoms by helping the depressed patient cope more effectively with interpersonal difficulties that are related to the depressive symptoms.

There are four main problem areas which are identified by IPT as most typically relating to depressive illness: grief, role disputes, role transitions, and interpersonal

deficits (Weissman & Klerman, 1990). The experience of coming to a foreign culture could easily precipitate any one of the four problem areas. Moving to a different culture necessarily involves role transitions. The losses that are present in transitions, even if the changes are perceived to be positive, may exacerbate feelings of depression. As African American adolescents attempt to make transitions into the dominant White culture, they may experience this feeling of depression because the culture is so foreign from their culture. Because of racism and other social problems, African American adolescents may resort to use of crack as a means to inoculate themselves from the dominant culture. The onset of depression in culturally different populations is often accompanied by difficulties in acclimatizing to the new environment encountering seemingly insurmountable obstacles and difficulties adjusting to new roles and new interpersonal dynamics with friends, family, and inhabitants of the host culture (Weissman & Klerman, 1990). Based upon this information, IPT may be a viable treatment option for depressed African American crack addicts.

Psychoeducational Approaches to the Cultural Management of Depression

Outpatient counseling may also include psychoeducational approaches that combine therapeutic techniques with information giving (Gingerich et al., 1992). Within this treatment modality the therapists take on the additional role of an educator. Psychoeducational programs aim to teach people about depressive illness by helping to enable or to empower them to better cope with symptoms and to more fully understand the accompanying biological and cognitive processes. Psychoeducational sessions for depressive illness may include content on etiology, heritability, symptoms, and treatment

(Gingerich et al. 1992). Psychoeducational approaches may be provided to both the depressed persons and their families in cultural groups. For instance, modules and educational material should ideally be presented in the native language of the participants. Therapists should consider the ways in which information in conveyed and presented, adjusting psychoeducational material to accommodate cultural and linguistic barriers.

Again it is necessary to note that the focus will be placed upon depression because it can be addressed by mental health professionals. By acquiring an understanding of the condition, both the patient and family will be better able to cope with depressive illness. Gingerich et al. (1992) found that families involved in psychoeducational sessions gained support by having their illness-related experiences and emotions validated by other group members. They also supported each other on issue pertaining to communications with health care providers. This may be particularly pertinent for African American adolescents who have not yet learned to navigate in the local health care system. In addition, family involvement in psychoeducational programs enables the therapist to understand and consider the cultural context in which the depressed person is being treated. Psychoeducational family treatment will enlighten clinicians as to the personal, social, and community resources available to the patient, in addition to barriers or obstacles present in the patient's environment, which may hinder recovery. Culturally stigmatized behavior of the African American crack addict can be discussed in connection with the treatment and the illness itself (Gingerich et al. 1992)

Another culturally sensitive psychoeducational intervention that may be helpful to

African American crack addicts entails the therapist identifying the observed differences in the presentation of depressive disorders (Kazarian & Evans, 1998). Evidence suggests that there are universal aspects to the condition, and there are multiple ways in which it can present. The various manifestations are mediated by the sociocultural circumstances of individual (Kazarian & Evans, 1998). Observed differences in the presentation of depressive disorder are frequently attributable to differences in cultural norms of expression. However, the culturally competent clinician who is able to sift through the symptom presentation and distinguish the cultural artifacts from the core symptoms will note that the clinical picture of depressive disorder is similar across cultures (Kazarian & Evans, 1998).

Involvement of Extended Family Members in Treatment

Family pressure to confront problems associated with drug use may also be absent when cultural values place constraints on familial communication (Ja & Aoki, 1993, p.65). African Americans, as well as many other cultural groups, are described as being more strongly "familistic," which typically entails a more extended family network that extends even to nonrelatives, than the dominant White culture (Ja & Aoki, 1993). Several authors (Gaines, 1985: Marin, 1990) have argued that a strong familistic connection may make it more difficult for clients from diverse cultures to seek and accept treatment from professionals, who are seen as strangers. Therapists who are treating the African American crack users can benefit from the inclusion of one or more of the key extended family members within the therapy sessions.

Suggestions by these key figures may be included in the treatment planning which helps enhance the efficacy of the therapist (Gaines, 1985: Marin, 1990).

Use of Medication

A treatment that has been shown to be effective for crack withdrawal involves the use for medication utilized psychotropic medications to treat adolescent crack addicts (Galloway et al., 1994; Wallace, 1991). This treatment is not a culturally specific treatment for African American adolescents. However, it could be useful for any individual who is trying to withdraw from crack. One of the medications used was Imipramine. Imipramine is a tricyclic antidepressant medication used to treat depression, attention deficit disorders, and panic disorders. Adolescent patients who use this medication have a higher success rate in inpatient treatment of crack addictions because this medication reduces the painful effects of withdrawal. Crack addicted adolescents undergoing withdrawal from crack report unpleasant side effects for usually several weeks, including depressed mood, craving, and anhedonia. Fifty four percent of the 151 subjects within this study were African American crack smokers including adolescents between the ages of 16 and17 years of age (Galloway et al., 1994). The results of this study indicated that the adolescent who ingested doses of 150 mg of Imipramine remained in treatment for a longer period of time because the Imipramine alleviated the anhedonia, craving, and anergia symptoms of withdrawal. Withdrawal characteristics play a significant role in treatment and retention of adolescent patients in treatment as discussed above (Galloway et al., 1994).

Another medication, desipramine, has proven to be minimally effective in aiding a group of 58 African Americans who were involved in a crack treatment program (Campbell et al., 1994). Again, this treatment regimen is not culturally specific, but has been demonstrated to be effective in assisting adolescents to withdraw from crack. Desipramine like Imipramine is a tricyclic antidepressant drug which is used to treat depression, attention deficit disorder, bulimia, and cocaine withdrawal (Halikas, et al., 1993). Subjects did attend more outpatient treatment activities while being treated with desipramine. However, it has been noted that the sample size of the study may have been too small to truly test the efficacy of desipramine (Campbell et al., 1994).

The results of one study suggested that methadone treatment programs have appeared to be effective treatment modalities for adolescent crack abusers (Prichep et al., 1996). Within this methadone treatment program the African American crack addicts are gradually weaned from the crack cocaine. The methadone helps the adolescents to withdraw from crack with seizures or immense pain. This is a more regulated withdrawal, such as is used with heroin addicts (Mangura et al., 1994).

It is essential that mental health therapists must gain the trust of the African American adolescent's family when using medication or treatment. The adolescent and or his family may feel doubtful or reluctant to consider methadone treatment because it utilizes another drug to help the adolescent crack user to withdraw from crack (Miller, Summers, & Gold, 1993). The mental health therapist can meet with the family, preferably within their home, to provide educational sessions which outline what the methadone treatment will involve. It would be helpful if other extended family members

who play an important role in the adolescent's life could be present at these sessions. Special care must be taken to help the family understand the adolescent will not become a methadone addict (Mangura et al., 1994).

Many of the subjects of this study began abusing crack and other illicit drugs during their adolescent years (Mangura et al., 1994). Self-esteem and self-efficacy were continuously reinforced. Sixty two percent of the participants reported that smoking crack was their most frequently employed method (Mangura et al., 1994). Fifty percent of the participants remained in the treatment program for six months due to receiving methadone. Six months was the length of the program. The study indicates that by using methadone some of the participants remained for the duration of treatment. Within the methadone treatment 92% of the subjects were African Americans or Hispanics who abused crack (Mangura et al., 1994). The methadone intervention entailed cognitive behavioral therapy which involves cognitive restructuring (identifying, modification of maladaptive thought patterns which facilitate cocaine use), coping skills training development, and rehearsal of strategies for dealing with stress. Relapse prevention treatment includes methadone treatment and the development of alternative leisure activities (Mangura et al., 1994).

Therapeutic prevention techniques which included methadone provide treatment alliances between the African American patients and therapists by use of consistent positive reinforcement to engage and maintain the patients in treatment. In Stage I of recovery, patients are guided though observed neuropsychological stages of recovery from stimulant abuse classified by the model as "withdrawal," "honeymoon," "the wall,"

"adjustment," and "resolution." "Predicting and explaining the stages at the outset of therapy has shown promise as an effective clinical tool "(Mangura et al., 1994, p. 145).

Two of the five therapists were African American, and one was Hispanic. The inclusion of minority therapists was essential to this model because the therapists were hypothesized to be better prepared to relate to minority clients who had minimal experiences in counseling. This treatment was designed to help the African American client and Hispanic clients to achieve small goals in their recovery. The program also provided opportunities for recovered clients to serve as senior role models for the other community members. One important component of this program was that it refrained from employing interventions which included criticism and penalties for lapses with the primary goal of minimizing any forms of punishment or disorganization of the African American adolescent development while undergoing treatment (Mangura et al., 1994).

In a second methadone treatment study, researchers discovered that individuals remained in treatment longer when they were receiving methadone in addition to vouchers for each clean urine sample (Silverman et al., 1996). African American adolescents and adults received vouchers which they could use to purchase goods and services each time they delivered a clean urine sample (Silverman et al., 1996). This program was provided to African American participants who lived in the inner city. The adolescents within this study had to be at least 18 years old in order to receive methadone. Patients also qualified for the program if they were addicted to crack cocaine and reflected a history of injecting crack cocaine (Silverman et al., 1996). Of the last six patients who were involved in the residential treatment, four remained. The program

lasted for five weeks and leaving against medical advice was a common problem. Use of methadone decreased the risk of leaving treatment prior to completion (Silverman et al., 1996). The methadone maintenance program with voucher based regimen therapy reinforced abstinence from crack use (Silverman et al., 1996). The first crack free urine sample earned a voucher worth $2.50 and thereafter the vouchers increased in value by $1.50 for each crack free urine sample. If the patient received six consecutive crack cocaine urine free samples, the amount of the sixth voucher increased to the highest value that the patient had achieved previously. If a patient could remain abstinent for twelve consecutive weeks, he or she could earn approximately $1155.00 in vouchers (Silverman et al., 1996).

Approximately 26 of the total of 52 participants remained abstinent from crack usage for 7 to 12 weeks of the 12 week program (Silverman et al., 1996). The remaining half of the participants did experience some dirty urine samples and therefore did not earn consecutive vouchers. This program has been shown to be effective with African American adolescents as well as with Caucasian clients because it systematically reinforces abstinence.

Family Therapy

Family counseling is another approach which can be effective in helping the adolescent crack user. By working with the family of the adolescent, the counselor may better assess the way in which the family "does its dance," so to speak. The counselor can identify how each member of the family identifies his or her problems (Vernon, 1993). How the family members interface with one another and how members of the

family communicate with each other could be key questions to explore by the counselor. The counselor can negotiate goals for the family so that each family member can commit to them. The adolescent gains support during recovery as a result of the family's commitment to working towards the same goals.

Many parents of adolescents who use crack believe that all their child needs to do is to be self-disciplined and simply just stop using cocaine. However, the brain's reward center's forceful pull to receive more crack is too strong for the adolescent to simply stop using crack after he or she has become addicted (Wallace, 1991). Mental health counselors must educate these parents so that they truly understand that their child may not have the ability to stop using crack by simply having a desire to stop.

Friedman (cited in Christoph & Sequeland, 1996) investigated psychosocial interventions offered within a six month course of family therapy versus parent groups in the treatment of adolescent substance abuse. Techniques used within this family strategic model involved tasks, directions, problem solving, and positive relationships, and communications skills work. The parent group was composed of only parents as the adolescents were simultaneously receiving individual therapy (Christoph & Siqueland, 1996). The results of this study indicated that family therapy was more effective in the treatment of African American adolescent abuse using crack. The authors of this study recommended the use of a community reinforcement program, which had been shown to be effective in treating African American adolescent crack abusers. These adolescents reduced drug use after involvement in family therapy and had better retention in treatment.

Developing Alternate Coping Strategies

Adolescents who are recovering from crack addiction or crack use may have periods of irritability, anger, and anxiety. Counselors may assist these adolescents by helping them to learn alternative coping strategies (Vernon, 1989). One coping strategy may be to learn effective ways of resolving conflicts. Members of dysfunctional families often allow their problems to remain unresolved, which can contribute to the adolescent crack user harboring feelings of resentments and anger (Wallace, 1991). The counselor can help the adolescent and or his or her family learn how to communicate with family members in noncombative ways when problems or conflicts arise (Vernon, 1989).

As with the use of many other drugs, crack users often use these drugs in the company of their peers. Adolescent recovering from crack can possibly benefit from exploring the relationships that they have been involved in when they were using crack. The counselor can help the adolescent to identify if these relationships were healthy or unhealthy by helping the adolescent to make such a distinction (Vernon, 1989).

Intervention strategies can be directed towards helping the adolescent to understand what an " unhealthy dependent" relationship is (one in which the adolescent relies on someone who is controlling he or she) and learning how to develop new friendships which are not dependent. Adolescents can be assisted in exploring the high probability of relapse if they continue to retain unhealthy dependent relationships with their peers who continue to use crack (Wallace, 1991).

Attitudes of Treatment Professionals

The beliefs and attitudes of the staff members of treatment programs may

influence who comes to treatment and how they are treated once they do come (Jordam & Oci, 1989; Rodin, 1981). Treatment personnel often hold stereotypical views about appropriate presenting problems and prognoses for different cultural groups or for males and females. As recent as the 1950s, some clinicians believed that African Americans were beyond counseling. Treatment providers need to examine any preconceived beliefs they may have about clients and how these may affect the treatment given.

Through the awareness of cultural values of African Americans, therapists and resource personnel can increase their sensitivity to the nonmainstream values of African Americans that may influence the impact of education, assessment and treatment (Gonzalez, Biever, & Goardner, 1994). This can reduce the tendency to try to fit the client to the therapist's views of substance abuse. The clinician must also understand, for example, that asking questions, in African American and other cultures, may be viewed as a challenge, and therefore is often avoided by the patient (Wayman, Lynch, & Hanson, 1991).

The culturally aware therapist knows that body language, goal setting, decision-making styles, and assessment tools are all culturally laden (Pederson, Fukuyama, & Heath, 1989). An important multicultural skill is the ability to be flexible and "ready to modify, accept and experiment" (Pederson, et al., 1989, p. 32). This may include the use of information networks or the recognition of the need for a referral to a more culturally similar therapist (Sue & Sue, 1990).

Cognitive Behavior Therapy is an adaptable method, requiring a therapist who is aware of culturally normative processes (Kazarian & Evans, 1998). For example, the

therapist must be able to recognize symptoms of hopelessness, helplessness, and worthlessness as they manifest in the African American cultures. They must then shape the course of therapy in accordance with the cultural context of African American crack using patient. Cognitive behavioral techniques can be modified as the therapist becomes familiar with normative cognitive processes of the African American adolescent's reference group (Kazarian & Evans, 1998).

A study by Curtiss, Lenz, and Frei (1993) suggested that treatment approaches for African American adolescents crack addicts must involve African Americans as providers of the treatments. These researchers discovered that there was a high level of mistrust of health care providers by members of the African American communities, especially those providers who deliver mental health services. They found that often African American adolescents were fearful of disclosing to White mental health providers because they viewed them as part of the system which may discriminate against people of color (Curtiss et al., 1993).

This study indicated that adolescents from African American families who received AFDC learned to be cautious of social workers who come to their homes (Curtiss et al., 1993). These same adolescents were reluctant to disclose to non-African American mental health therapists in the same way because they feared that the social workers who have the ability to discontinue their family's source of income, or the ability to lock them up in a mental institution where they are robbed their freedom like their ancestors who were bound as slaves (Curtis et al., 1993).

This fear of Caucasians, one author explained (Akbar, 1984), may be related to personal inferiority. Na'im Akbar (1984) proposed that many African American families have developed an inferiority complex when comparing themselves to Caucasian counterparts. He suggested that this feeling of personal inferiority came about as "shrewd slaveholders" three hundred years ago would dehumanize slaves by parading them on slave blocks unclothed and by inspecting them like cattle or horses (Akbar, 1984, p. 20). He further postulated that African American adolescent who abuse drugs such as crack cocaine do not seem to respect their lives due to this sense of inferiority.

Based upon these concerns, outpatient treatment must include efforts to increase self-esteem and self-respect within African American adolescents (Akbar, 1984). Interventions, which include exposure of the adolescents to powerful and dignified images of people who look like them, may be helpful in decreasing or eliminating the personal inferiority complex described by Akbar (1984).

African American adolescents may perceive counselors to be "representatives" of a dominant system that they may oppose (Kazarian & Evans, 1998). These adolescents may display heavy transference of emotions. A culturally sensitive therapist will anticipate such situations during treatment and assist the African American adolescents in redirecting their high energy level to working to change the undesirable conditions under which they exist. A counselor should not allow the client's negative outward behavior to serve as an excuse to reinforce the counselor's hidden cultural prejudices. Therapists who suffer from retaliatory hostility sometimes make remarks such as the following:

"She's just another angry woman."

"Give them an inch and they'll take a mile."

"If they don't like it here, why don't they go back to Africa."

"If they stayed in their neighborhood, we wouldn't be having these troubles." (Axelson, 1999).

Therapists must try to prevent maintaining these stereotypical beliefs in order to foster a cross-cultural exchange of open-minded understanding, tolerance, and helpfulness (Kazarian & Evans, 1998). During a human relations encounter group session, an African American participant spoke up to the White participants, "Why is it you Whites can't be up front with us?" (Axelson, 1999, p. 200). Out of the intense communication and confrontation on Black-White issues in the late 1960s and early 1970s, Lee and Schmidt (1969, pp. 4-5) developed the assumptions and behaviors on the part of both African Americans and Whites that can either block or facilitate authentic relations (see Appendix)

Conclusion

The author of this paper has addressed the significance of the development of treatment strategies to implement with African American adolescent crack addicts. An integral basis for tailoring culturally specific treatment approaches for African American adolescents relates to the unique circumstances, which may promote more extensive crack abuse by this group. Depression was the difficulty which the author chose to focus upon. Several different methods of helping these adolescents have been discussed. The intervention strategies which show promise in helping African American adolescent crack addicts include: (a) Interpersonal Therapy; (b) psychoeducation programs; (c)

involvement of family members in treatment; (d) use of medication; (e) family therapy; and (f) developing alternate coping strategies. Lastly the attitude of the therapist appears to be important in addressing the multicultural issues of this special population.

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Appendix

Assumptions Whites Make that Block Authentic Relations

1. Color is unimportant in interpersonal relations.
2. Blacks will always welcome and appreciate inclusion in White society.
3. Open recognition of color may embarrass Blacks.
4. Blacks are trying to use Whites.
5. Blacks can be stereotyped.
6. White society is superior tc Black society.
7. "Liberal" Whites are free of racism.
8. All Blacks are alike in their attitudes and behavior.
9. Blacks are oversensitive.
10. Blacks must be controlled. (Lee & Schmidt, 1969, pp. 4-5)

Assumptions Blacks Make that Block Authentic Relations

1. All Whites are alike.
2. There are no "soul brothers and sisters" among Whites.
3. Whites have all the power.
4. Whites are always trying to use Blacks.
5. Whites are united in their attitude toward Blacks.
6. All Whites are racists.
7. Whites are not really trying to understand the situation of the Blacks.
8. Whites have to deal on Black terms.

9. Silence is the sign of hostility.

10. Whites cannot and will not change except by force.

11. The only way to gain attention is through confrontation.

12. All Whites are deceptive.

11. 13. All Whites will let you down in the "crunch." (Lee & Schmidt, 1969, pp. 4-5)

Assumptions Whites Can Make that Will Facilitate Authentic Relations

1. People count as individuals.

2. Blacks are human-with individual feelings, aspirations, and attitudes.

3. Blacks have a heritage of which they are proud.

4. Interdependence is needed between Whites and Blacks.

5. Blacks are angry.

6. Whites cannot fully understand what it means to be Black

7. Whiteness/Blackness is a real difference but not the basis on which to determine behavior.

8. Most Blacks can handle Whites authentic behavior and feelings.

9. Blacks want a responsible society.

10. Blacks are capable of managerial maturity.

11. I may be part of the problems. (Lee & Schmidt, 1969, pp. 4-5)

Assumptions Blacks Can Make that Will Facilitate Authentic Relations

1. Openness is healthy.

2. Interdependence is needed between Blacks and Whites.

3. People count as individuals.

4. Negotiations and collaboration are possible strategies.

5. Whites are human beings and, whether they should or not, do have their own hang-ups.

6. Some Whites can help and "do their own thing"

7. Some Whites have "soul." (Lee and Schmidt, 1969, pp. 4-5)

Behaviors of Whites that Block Authentic Relations

1. Interruptions.

2. Condescending behavior.

3. Offering help where not needed or wanted.

4. Avoidance of contact (eye-to-eye and physical).

5. Verbal focus on Black behavior rather than White behavior.

6. Insisting on playing games according to White rules.

7. Showing annoyance at Black behavior that differs from their own.

8. Expressions of too-easy acceptance and friendship.

9. Talking about, rather than to, Blacks who are present. (Lee & Schmidt, 1969, pp. 4-5)

Behaviors of Blacks that Block Authentic Relations

1. Confrontation too early and too harshly.

2. Rejection of honest expressions of acceptance and friendship.

3. Pushing Whites into such a defensive posture that learning and reexamination are impossible.

4. Failure to keep a commitment and then offering no explanation.
5. "In-group" joking, laughing at Whites-in Black culture language.
6. Giving answers Blacks think Whites want to hear.
7. Using confrontation as the primary relationship style.
8. "In-group" isolationism. (Lee & Schmidt, 1969, pp. 4-5)

Behaviors of Whites that Facilitate Authentic Relations

1. Directness and openness in expressing feelings.
2. Assisting other White brothers and sisters to understand and confront feelings.
3. Supporting self-initiated moves of Black people.
4. Listening without interrupting.
5. Demonstration of interest in learning about Black perceptions, culture, and so forth.
6. Staying with and working through difficult confrontations.
7. Taking a risk (being first to confront the differences).
8. Assuming responsibility for examining own motives-and where they are. (Lee & Schmidt, 1969, pp. 4-5)

Behaviors of Blacks that Facilitate Authentic Relations.

1. Showing interests in understanding Whites' point of view.
2. Acknowledging that there are some committed Whites.
3. Acting as if "we have some power"-and don't need to prove it.
4. Allowing Whites to experience an awareness of racism.
5. Openness.

6. Expression of real feelings.
7. Dealing with Whites where they are.
8. Meeting Whites halfway.
9. Treating Whites on one-to-one basis.
10. Telling it like it is.
11. Realistic goal sharing.
12. Showing pride in one's heritage. (Lee & Schmidt, 1969, pp. 4-5)