CHAPTER 3

African American Children and Health Issues

OVERVIEW

For the past two decades, initiatives at both the national, state and community levels have been implemented to ensure access to quality health care for all children in the United States. Despite these efforts, African American children are disproportionately affected by certain health conditions and have limited access to quality health care.

The focus of this chapter is to discuss the health challenges that confront African American infants and children, as well as to discuss their access to health care. The chapter is divided into two sections.

Section one begins with a discussion of infant mortality. The overall infant mortality rates have decreased, yet the rates for African American infants remain higher than the national average. The section continues with information on the health conditions that disproportionately affect African American children. Those health conditions include AIDS, lead poisoning, sickle-cell anemia, asthma, and obesity.

Section two commences with a discussion of health care coverage for African American children, a discussion of the barriers to quality health care and concludes with a discussion of federal and state initiatives designed to reduce barriers and to improve both access and the health status of African American children.

The chapter ends with a discussion of perspectives on health status and access to health care and African American children in the 21st century.

SECTION ONE: HEALTH CHALLENGES

Infant Mortality

INSIDER'S VOICE: INFANT MORTALITY

For the Love of a Child

Determined to keep babies from dying, Kathryn Hall pairs "sister-friends" with pregnant women who have nowhere else to turn.

By Bettijane Levine, *LA Times,* Feb. 1992

Sacramento—For 14 years, Kathryn Hall used the term infant mortality and thought she knew what it meant. She was after all a public health administrator, who oversaw millions of dollars of state funds. Then she held a dead baby in her arms for the first time. He was an infant who need not have died. But his mother was poor, diabetic, and often too sick to get to the clinic by bus. Hall, who heard about the woman through a public health nurse, drove to her house and took her to the clinic. But it was already too late. The baby was in extreme respiratory distress and had to be delivered by C-section. He underwent brain surgery and remained on life support until he died 10 days later.

Kathryn Hall worried about the infant death rate for years. As a state administrator, she was angered by the astonishing statistics about black babies in California. "They die at twice the rate of white babies, their birth weights are lower than all the rest," she says. Worse yet, it seemed that policy makers had begun to take the statistics for granted. "I heard them say things like maybe black babies just naturally die more, just naturally have lower weights. Those assumptions were not okay with me." She shifted into high gear and in 1988 decided to start a plan to help grow healthy black babies. She recruited Black middle class women and paired them with pregnant women. They were called sister friends and each sister friend maintained daily contact with the mother, making sure that doctor appointments were kept and medicines were taken. These sister friends saw the mother and the child until the end of the baby's first year.

Word spread that the volunteers were making dramatic differences in their sisters' lives. Birth weights were up; the death rate fell to zero. About 300 babies have been born in the project, at an average birth weight of more than 8 pounds.

Grant money for the project was secured from the Sierra Health Foundation and from the Irvine foundation.

This birthing project is not only thriving in Sacramento, but also in Los Angeles and in 34 other states as well.

Kathryn Hall's story aptly captures the severity of the problem of infant mortality that exists within the African American community.

The overall infant mortality rate in the United States has significantly decreased in the past 40 years. This is due in part to better health care available to pregnant women, and in part to the advances made in the field of neonatology. However, even with the increase in access to prenatal care, and advances in the field, the mortality rates, as well as the morbidity rates for African American infants, remain higher than the rates for White infants and infants from other ethnic groups (see Figure 3.1).

As the figure illustrates, in 1960 the infant mortality rate for African American infants was 44.3 per 1,000 live births, whereas the infant mortality rate for White infants was 22.9 per 1,000 live births. In 1970, the infant mortality rate for African American infants dropped to 32.6 per 1,000 live births and to 17.5 per 1,000 live births for White infants. For the past 20 years, the infant mortality rate for African American infants decreased, from 21.4 in 1980 to 17.4, 14.0, and 13.9 in 1990, 2000, and 2002, respectively.

Despite this decreasing trend, African American infants are 2 to 4 times more likely to die in infancy than White infants and infants from other ethnic groups.

Infant mortality rates tend to vary by state and the state rates are often higher than the national rates. As Table 3.1 indicates, states such as Wisconsin, Colorado, Nevada, Michigan, Ohio, Tennessee, and Illinois have the highest African American infant mortality rates. However, regardless of the state, the mortality rates for African American infants remain higher than the national average (Statistical Abstracts of the United States, 2003).

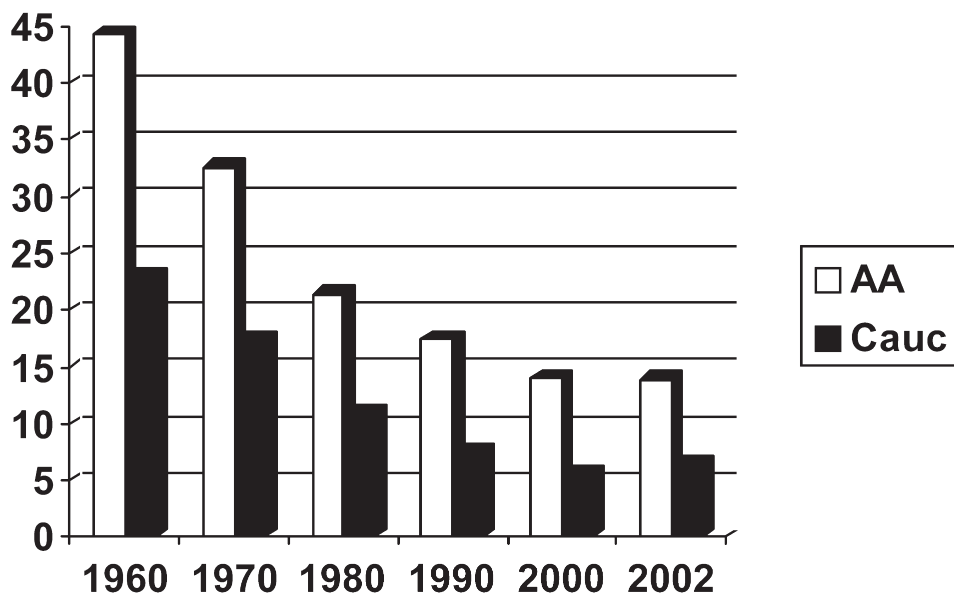


FIGURE 3.1 Infant mortality statistics for African American infants and White infants. Source: (National Vital Statistics Reports, Vol. 52, No. 3, September 18, 2003).

TABLE 3.1 Infant Mortality State Rates (FY 2002)

State	Rate
Alabama	13.9
Arizona	13.0
Arkansas	13.9
California	12.9
Colorado	21.1
Connecticut	14.2
Delaware	12.9
District of Columbia	14.5
Florida	13.6
Georgia	13.7
Illinois	16.3
Indiana	15.3
Kansas	15.2
Kentucky	14.2
Louisiana	15.0
Maryland	12.3
Massachusetts	9.1
Michigan	18.5
Minnesota	10.3
Mississippi	14.8
Missouri	17.1
Nebraska	20.8
Nevada	18.4
New Jersey	12.8
New York	9.9
North Carolina	15.6
Ohio	17.7
Oklahoma	17.2
Pennsylvania	15.1
South Carolina	15.8
Tennessee	18.3
Texas	13.5
Virginia	14.6
Washington	12.7
Wisconsin	18.9

Source: U.S. Census Bureau, Statistical Abstract of the U.S. 2006.

What accounts for this disparity in infant mortality rates? Why do more African American infants die within their first year of life?

The two primary causes frequently cited in the medical and health literature are infant health status and maternal risk factors. A conceptual model of infant health status and maternal risk factors is presented in Figure 3.2.

African American infants at risk for dying during their first year of life are those who are preterm, have low birth weight, are exposed to drugs in utero, or suffer from a host of medical problems.

Data released by Centers for Disease Control (2000), and www.cdc.org, indicated that in 1998, 6.5% of all White infants were underweight at birth, whereas, 13% of African American infants were underweight at birth; in 2002, 6.8% of White infants were low birth weight, 13.3% of African American infants were low birth weight, and in 2003, 6.9% of White infants were low birth weight and 13.3% of African American infants were low birth weight. The percentage of infants weighing less than 1,500 grams (those at greatest risk for disability) has increased to 18% for infants of African American mothers (Health United States and Healthy People Review, 2000, Child Health USA, 2004). In fact trend data suggest that the very low birth weight rates have increased for African American infants from 1985 to 2002, from 2.7 per 1,000 live births to 3.1 per 1,000 live births (Child Health USA, 2004).

As a consequence of their low birth weight and premature status, these infants are born with a plethora of medical complications, which include congenital defects such as cleft palate, (National Center for Health Statistics, 2004) and infectious diseases (Petrini, Russell, Posthman, Davidoff,

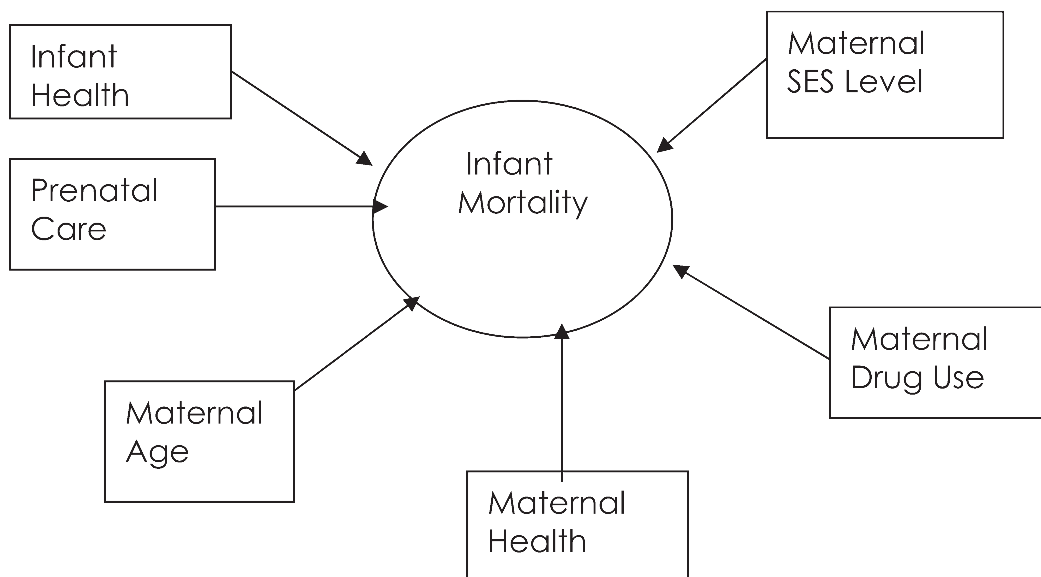


FIGURE 3.2 Infant health status and maternal risk factor model.

& Mattison, 2002). Because of their medical complications, a number of these infants do not live long after delivery (Rosenberg, Desai, & Kan, 2002).

For those infants exposed to drugs in utero, fetal addiction accompanies maternal addiction. Withdrawal symptoms such as irritability, high-pitched cries, tremors, poor feeding, and fevers are seen in 60%–90% of the infants prenatally exposed to cocaine (Coles, 1992). Once ingested, cocaine crosses the placenta and disrupts the flow of oxygen and nutrients to the fetus. As a result, intrauterine growth retardation is common in pregnancies of women addicted to crack-cocaine, and consequently the infants are often born with low birth weight or preterm, and their mortality rates are high (Jacobsen, Jacobsen, & Sokol, 1994). Those babies who survive often experience long-term physical problems or congenital abnormalities, as well as a host of behavioral and cognitive problems as a result of cocaine's influence on the development of such brain structures as the caudate nucleus, the limbic system and the cerebral cortex (Ryan, Ehrlich, & Finnegan, 1987). Cocaine also interferes with the production of dopamine, norepinephrine, and serotonin (Singer et al., 2005). Therefore, as a result of the neurological and neurochemical damage, these infants often have difficulties executing basic motor functions such as crawling, walking, reaching and grasping; they experience problems in processing and retaining information, as well as problems regulating their emotions; damage to the cerebral cortex can also produce significant language delays and problems (Singer, et al., 2005).

Alcohol, like cocaine, crosses the placenta, and prenatal exposure to alcohol can result in either Fetal Alcohol Syndrome (FAS) or Alcohol Related Neurodevelopmental Disorder (ARND) (Astley & Clarren, 2000). Infants with FAS will exhibit prenatal and postnatal growth retardation, facial malformations, behavioral and state (e.g., shifting from wake states to sleep states) problems, and mental retardation (Mattison, Schoenfeld, & Riley, 2001).

Infants born with ARND do not have dysmorphia (facial malformations), but may exhibit some behavioral and cognitive problems that often go undetected until their preschool and school age years (Astley & Clarren, 2000).

In a comprehensive study of 483 African American infants exposed prenatally to alcohol, Burden et al. (2005) observed that prenatal exposure to alcohol was related to slower information processing times and lower Bayley Mental Development Index (MDI) scores at 6 months and 12 months. At age 7, these children had lower Weschler Intelligence Scale for Children III (WISC) arithmetic and digit span scores. Teacher reports at age 7 also indicated that these children tended to be more aggressive than non-exposed children and encountered more negative peer interactions than non-exposed infants.

According to the National Organization on Fetal Alcohol Syndrome, there has been an increase in the number of infants born with FAS. In 1979, the FAS rate was one case per 10,000 births, and the rate increased in 1999 to 6.7 cases per 10,000 live births. The incidence of FAS is 6.0 per 1000 live births among African American populations (National Vital Statistics, 2000).

In addition to the aforementioned factors, in contrast to White infants, African American infants are more likely to die from Sudden Infant Death Syndrome (Weese-Mayer et al., 2003).

Maternal Risk Factors

As the model suggests, maternal age, health status, entry into prenatal care, and maternal drug use are identified as the primary maternal risk factors. More recently, Jaffee and Perloff (2003) have explored the relationship between neighborhood risk factors (i.e., high poverty levels, high violence levels) and maternal psychological functioning (i.e., depression) and adverse pregnancy outcomes. Their findings suggest that mothers who live in high crime and low income neighborhoods and experience depression are those most at risk for poor pregnancy outcomes.

Although the maternal risk factors may independently contribute to adverse pregnancy outcomes, it is plausible that they interact and increase the chances of birthing an infant who will die within the first year of their lives.

Age. African American mothers at the greatest risk are between the ages of 20 and 24, and between the ages of 35 and 54 years. The infant mortality rates for these mothers were 15.5 per 1,000 live births and 16.3 per 1,000 live births respectively in 2005 (Office of Minority and Women's Health, 2006; see their Web site, www.bhpc.dhhs.gov/omwh). Maternal death is not uncommon for these mothers and they are twice as likely to die from hemorrhage and miscarriage (Geronimus & Bound, 1990). Data released by the Centers for Disease Control revealed that in 2002, the maternal death rate for African American mothers was 24.9 per 100,000 live births, whereas the maternal death rate for White mothers and Latina mothers was 5.8 and 7.1 per 100,000 live births respectively. The gap has widened since 2000 (Child Health USA, 2004).

Socioeconomic Status and Health. Studies generally find a higher incidence of poor pregnancy outcomes among women from lower socioeconomic status (SES) groups (Grady, 2005). Poor African American mothers are highly susceptible to conditions and diseases caused by nutritional inadequacies, and inadequate medical care (Friedman, Cohen, & Mahan, 1993). Prior to pregnancy, they are more likely than non-poor mothers to be undernourished and malnourished, and during pregnancy, they tend to gain less weight, and

to experience such health problems as anemia, eclampsia, diabetes and hypertension (Liberman, Ryan, Manson, & Schoenbaum, 1987).

Geronimus (1996) proposes the "weathering hypothesis" as a way of describing the link between maternal health, socioeconomic status and adverse pregnancy outcomes for older African American mothers. He argues that the cumulative effects of poverty and untreated medical conditions as well as unhealthy lifestyle, increase the likelihood of birthing an infant who will die within the first year of life. Fiscella (2003) proposes that in addition to poor health problems, maternal obesity, especially the unusually high level of obesity found in African American women, contributes to their poor health status, which ultimately contributes to adverse pregnancy outcomes.

Drug Use. During the 1980s cocaine use as well as the high incidence of other drug use among pregnant women and women in their childbearing years reached epidemic levels in the United States (Singer et al., 2005; Pursley-Crotteau, 2000). Precise statistics on the number of African American mothers abusing drugs during pregnancy is hard to obtain. Nevertheless, these women are typically polydrug users, and have a higher rate of such health problems, such as hypertension, hepatitis, and sexually transmitted diseases, all of which affect fetal growth and infant development (Jacobson, Chiodo, Sokol, Jacobson, 2002).

Prenatal Care. Receiving early and consistent prenatal care is essential in reducing the chances of birthing a low birth weight and preterm infant, in decreasing infant mortality rates and in preventing other adverse pregnancy outcomes.

Pregnant women generally initiate this care during the first trimester of their pregnancy and usually schedule one prenatal care visit per month throughout the duration of their pregnancy. During routine prenatal care visits, weight, urine, blood pressure, protein and blood sugar levels are measured and advice is given on nutrition and other pregnancy related issues (Kogan, Kotelchuck, Alexander, & Johnson, 1994)

According to data provided by Health Statistics (2003), 74% of African American pregnant women initiate early prenatal care. The 26% of pregnant African American women who fail to receive adequate prenatal care, as illustrated in Figure 3.3, are adolescent mothers and mothers older than 40.

Research has documented that a variety of internal and external barriers prevent adolescent African American women from seeking early and consistent prenatal care. For example, Lia-Hoagberg et al. (1992) observes that transportation issues as well as knowledge of the restrictions and time limits of the federal health insurance are cited by these mothers as barriers for receiving early and consistent care. York, Williams, and Munro (1993) report

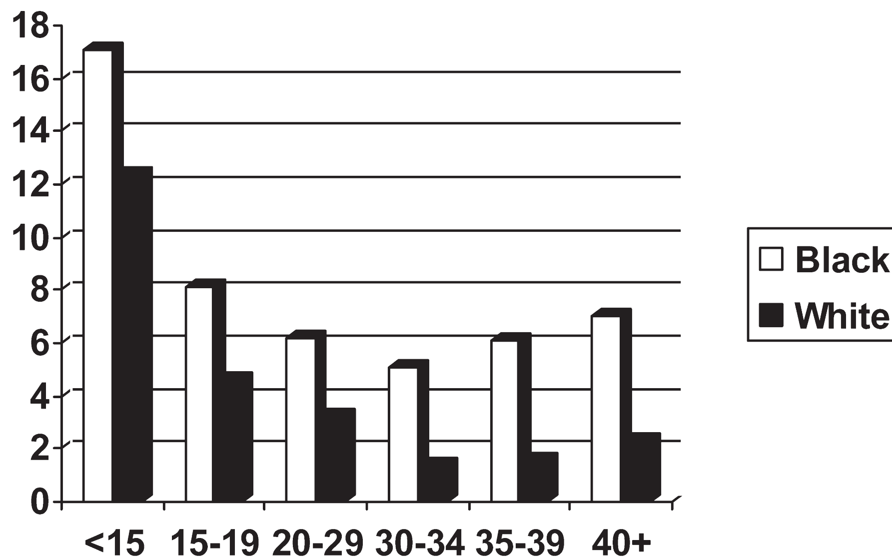


FIGURE 3.3 Percentage of mothers receiving late or no prenatal care, 2002.
Source: Child Trends Data Bank (2004).

that family functioning and child care issues emerge as barriers for this group of mothers. Reeb, Graham, Zyzanski, and Kitson (1987) found that young women experiencing family stress are less likely to receive adequate prenatal care. More recently, Paganini and Reichman (2000) found that martial status, planned versus non-planned pregnancy, city size, employment status, and maternal mental health are all factors for whether or not a woman receives prenatal care. According to Mikhail (2000), young and poor African American mothers report dissatisfaction with the quality of their prenatal care. These mothers indicate that they receive little information on nutrition and health issues during their prenatal care visits. In one report, African American mothers stated that the physician failed to inform about the risk of drinking and smoking, and the importance of good nutrition on pregnancy outcomes. This finding is consistent with recent studies showing that the quality of prenatal care services vary according to such dimensions as race and socioeconomic status (York, Tulman, & Brown, 2000).

Initiatives Designed to Reduce African American Infant Mortality Rates

Prevention and intervention programs have been designed at the federal, state, and community levels to address the problem of infant mortality in the African American community. Some programs were developed to increase access and use of prenatal care, while others were developed to reduce financial

barriers. Some programs targeted teen mothers, while others targeted poor mothers, regardless of age, living in urban and rural areas (see Brown (1989) for a review of those programs).

Women Infants and Children (WIC), a federal program authorized by Congress in 1972, is designed to reach at-risk pregnant women, their infants, and their children. The goal of WIC is to provide supplemental food (e.g., milk, eggs and cheese) information on nutrition and health, and access to prenatal care for pregnant mothers. Current estimates indicate that WIC provides benefits to 4.5 million women and their children monthly and access to prenatal care for 500,000 pregnant women (USDA, 2006).

As a result of WIC, such states as Florida, Michigan, Minnesota, North Carolina, South Carolina, and Texas have been successful in decreasing the infant mortality rates, increasing the survival rates of infants born to at-risk mothers, and improving maternal prenatal care (Avruch & Cackley, 1995: Devaney, 1992).

Healthy Baby/Healthy Start is another federally funded program, implemented in 1985. Similar to WIC, Healthy Baby/Healthy Start strives to reduce the financial barriers for pregnant mothers by subsidizing medical professionals and increasing the availability of prenatal care programs for pregnant women living in the urban areas.

Programs offered at the state level provide mothers with information by distributing literature in communities, using the media, or—as in the case of our Insider's Voice—using grass roots approaches to connect young and poor pregnant women with middle-class women.

Baby Your Baby Campaign and 961-Baby are examples of state level programs. To reach as many at-risk African American mothers as possible, Baby Your Baby Campaign employs a wide range of approaches, including the dissemination of pamphlets, broadcasting advertisements on local TV channels, and community advocacy. In addition to the campaign, a 24-hour hotline service, 961-Baby was founded by the Detroit-Wayne County Infant Health Promotion Coalition in 1985 (Brown, 1989). Trained professionals are available to provide information to callers on health and social services, and make referrals to prenatal care facilities. The clientele are typically unmarried African American women under the age of 18.

Home visiting programs have been established in several southern states designed to reach high-risk mothers in rural areas. These programs use lay women from the community to discuss the importance of prenatal and perinatal care. These home visiting programs have been effective in improving maternal nutrition and in increasing the prenatal care (Brown, 1989).

Individual states have designed perinatal and prenatal program which target at-risk women. These projects differ from the media campaigns and other

outreach efforts in that they provide comprehensive services (e.g., medical care, psychotherapy), and function in the role as data clearinghouses for infant mortality statistics.

Examples of those projects include a perinatal project in Alabama (Telfair, 2003), and a community based project in Michigan (Pestronk & Franks, 2003). Both of these programs involve discussions and focus groups with medical providers, community leaders and community members. As a result of the discussions, services have been targeted to those geographic areas with the highest African American infant mortality rates.

Physical Challenges Beyond Infancy

In this section we will discuss the physical challenges that African American preschool and school age children encounter. Although, many of these challenges emerge during infancy, they fully manifest themselves during the preschool and school age period and significantly impact the quality of life for preschool and school age children.

The section discusses AIDS, lead poisoning, with its effects on physical development and intellectual development; sickle-cell anemia, focusing on its incidence in the United States, describing its symptoms and physical manifestations, and discussing the psychosocial adjustment of school-aged children to the disease; asthma, with a focus on the types of medical management and community based programs available to African American children with asthma; and lastly, obesity and how obesity affects African American children in particular.

AIDS

The health concern that has the greatest impact on maternal, infant, and child survival within the African American community is AIDS. According to recent statistics released by the Centers for Disease Control, over half of all women infected with HIV/AIDS are African American and a substantial number of these women are in their childbearing years. These women are 23 times more likely to be infected with the disease than White women and accounted for the 71.8% of new HIV cases from 1999 to 2002 (Vital Statistics, 2003). Mothers infected with the virus have a 15% to 50% chance of birthing an infected infant (Bryson, 1996).

Data released by Child Trends Data Bank (2004), indicates that African American children under the age of 13 comprise 61% of all the pediatric AIDS cases diagnosed from 1985 to 2004, almost all of whom acquired the virus from their infected mothers.

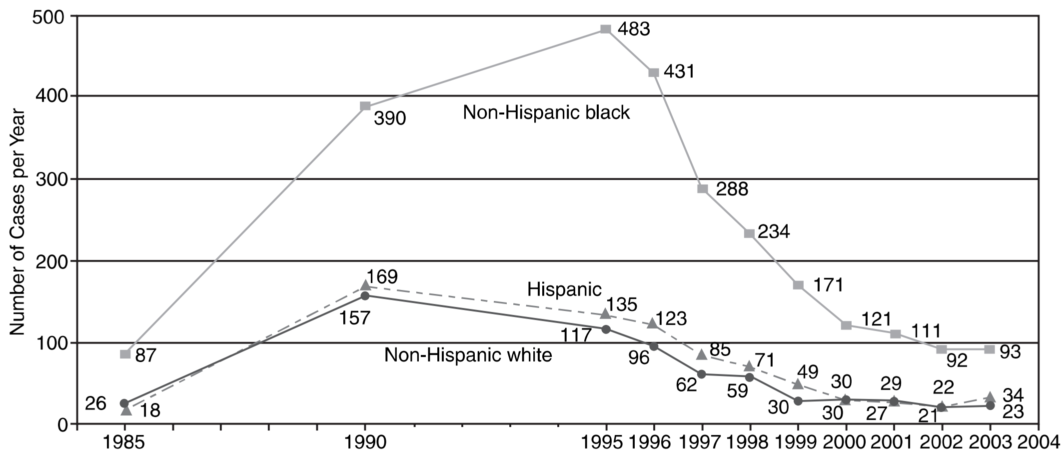
Figure 3.4 suggests that the number of AIDS cases has dramatically decreased in the past 20 years, but African American children remain 2 to 3 times more likely than their counterparts from other ethnic and racial groups to be diagnosed with AIDS.

The disease proceeds rapidly in those infants who acquired the disease in utero and most of these babies are born with abnormalities of the immune system (Landry & Smith, 1998). By 6 months of age, weight loss, fever, diarrhea and respiratory illnesses are common.

The virus can also cause serious brain damage. Infants with AIDS show a loss in brain weight over time, accompanied by seizures, delayed muscle tone and movements (Pollack, Kuchik, Cowan, & Hacimamutoglu, 1996).

Treatment of AIDS

In the last few years, there has been a reduction in the perinatal transmission of AIDS as suggested by the Figure 3.4. This is in part due to the use of the zidovudine (ZDV) drug treatment during pregnancy, as well as the use of an antiviral drug therapy administered to the newborn, immediately after birth and six weeks after birth (Battle et al., 1995). However, even with these advances, the number of African American children born HIV positive and the number of African American children with AIDS represents a continuing and persistent health concern for African American preschool and school age children.



Source: Data for 1996 and 1997 from National Center for Health Statistics. *Health, United States,* 2001 *with Urban and Rural Health Chartbook*. Hyattsville, Maryland: 2001. Table 53 Data for 1998 from National Center for Health Statistics. *Health, United States, 2002 with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland 2002: Table 54. All other data from: National Center for Health Statistics. *Health, United States 2003 with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland, 2003: Table 53. National Center for Health Statistics. Health, United States, 2004 with Chartbook on Trends in the Health of Americans. Hyattsville, Mary land, 2004.

FIGURE 3.4 Number of newly diagnosed AIDS cases among children under 13, by race and Hispanic origin, selected years, 1985–2003.
Source: Child Trends Data Bank www.childtrends.org

Plumbism

INSIDER'S VOICE: PLUMBISM

Motherly Advice on Lead and Children—Courtland Milloy

Maurci Jackson will never forget the words spoken by her 15-month-old daughter that day 5 years ago. "Mommy, I ate this," Maurissa said, holding up the remains of a dried piece of lead-based paint. For Marvette Lewis, the silence of her 2-year-old twin sons spoke just as loudly. "Neither boy was saying 'Mama' or 'Daddy' or any of the easy little things that I heard other children saying," Lewis said.

It turned out that eating lead based-paint had poisoned them. What followed was a nightmare for both mothers. For the next eight months, Jackson's daughter Maurissa underwent treatment that sometimes required having two injections a day with a 4-inch needle. Medical tests showed that Maurissa's blood contained three times the safe level of lead. The twins were subjected to intensive therapy in an effort to reverse their learning disabilities.

"My sons are doing better, but they are still not on the level that normal 4-year-olds should be," said Lewis.

According to a study by the U.S. Department of Housing and Urban Development, lead-based paint is found in about 5.7 million homes and young children live in 3.8 million houses with serious lead hazards. In predominantly black urban areas with relatively poor populations, such as Baltimore and Washington, up to 50% of young children are believed to be suffering from the effects of lead poisoning. These children experience such health risks as brain damage, hearing loss, and decreased growth.

Parents are now mobilizing. Some parent groups are calling for universal lead poisoning screening and treatment. Jackson said she is optimistic that her daughter will overcome the effects of lead poisoning. But what was most important, she said, was letting other parents know that lead poisoning is preventable and that no other child need ever suffer from it again.

Plumbism (or lead poisoning), a disease primarily affecting children under the age of six, is caused by exposure to high levels of lead. Although children are exposed to lead from a variety of sources, the primary source of exposure comes from lead-based paint used in the interior of older and dilapidated homes. As stated in the Insider's Voice, it is estimated that 3.8 million children are currently living in homes that have leaded paint surfaces. Moreover, the Northeast region of the United States, which is considered to be the lead belt, has the greatest number of children living in these homes (170,000), followed by the Midwest (139,000), the Southern region (130,000), and the West (77,000) (Mushak, Davis Crocetti, et al., 1989).

Lead poisoning causes the deaths of 200 children annually and 800 are so severely impaired that they will require permanent care. Three thousand two hundred more children sustain moderate to severe brain damage (Coscia, Douglas, & Dietrich, 2003). Unfortunately a disproportionate number of these children are poor, urban African American children. Three percent of African American children in comparison to 1% of White children have elevated blood levels (National Center for Environmental Health, 2006). The prevalence is higher for children between the ages 1 and 2 (Williams, 2002).

Most children with lead poisoning are asymptomatic (not displaying symptoms). If they do exhibit symptoms, these symptoms are similar to those common to most childhood illnesses and are often misdiagnosed as such. Usually developmental delays, and persistent cognitive and physical problems, signal parents that their child is suffering from something more serious than a common childhood illness.

What are the effects of lead poisoning on physical and intellectual development? Exposure to lead results in delayed physical growth, retarded motor development, and perceptual motor coordination problems (Dietrich, Berger, & Succop, 1993). Children exposed to lead also experience such physical problems as kidney disease convulsions, sleep disturbances, blindness, and cerebral palsy (Needleman & Bellinger, 1991). Exposure to lead can also lead to mental retardation, learning disabilities, attention and concentration problems, and language and speech delays (Wigg, 2001).

Unfortunately, without early detection and treatment of lead poisoning some of these learning problems persist well into adolescence, where they manifest themselves as severe emotional and behavioral problems (Coscia, Ris, Succop, & Dietrich, 2003).

Treatment of Plumbism

Lead poisoning is currently treated by a procedure referred to as chelation therapy (Angle, 1993). Chelation therapy involves administering to the child a chelating agent, which is a drug such as Dimercaprol (BAL), Ethylene diamine tetracetic acid edetate calcium disodium (EDTA) Penicillamine or Dimercaptosuccinic (DSMA) that binds to the lead in the body. The lead is removed from the body through waste material. The type of drug used depends on the amount of lead in the body. For example, Penicillamine and DMSA (both of which are orally administered) are used with children with relatively low amounts of lead poisoning, whereas EDTA and BAL (which are injected) are used with children with higher concentrations of lead in their systems. The duration of chelation therapy varies according to the level of lead in the

body; thus, treatments may range from 5 days to 6 weeks. The toxic effects of the drugs are minimal but chelation therapy provides rapid relief of acute symptoms reduces blood lead levels and results in an increase in growth velocity (Angle, 1993).

Without the complete removal of the lead from the home (lead abatement) or relocation to a lead free environment, the likelihood of lead recontamination is high.

A project sponsored by the National Safety Council's Environmental Health Center called the Lead Poisoning Prevention Outreach Program conducts meetings in the affected communities to help residents plan and execute successful lead poisoning prevention and abatement programs (see Dilworth-Bart & Moore (2006), for a review of lead abatement programs). In addition to this effort, the CDC designed the High Intensity Targeted Screening project which includes four components. The first two directly target affected children and their families. The first component is Door-to Door Screening. Homes in high risk communities are visited by health practitioners for screening and blood lead level testing. The second is intervention. Children with elevated lead levels receive treatment and homes are evaluated for lead abatement procedures. The third and fourth components focus on monitoring communities, implementing community prevention programs, and evaluating community compliance with lead abatement procedures (see CDC Web site for abatement programs, www.cdc.gov/nceh/lead).

Sickle-Cell Anemia

INSIDER'S VOICE: SICKLE-CELL ANEMIA

2 Georgia Boys May Be Proof of Sickle-Cell Anemia Cure

By Anne Rochelle
Atlanta Constitution, September 1, 1994

Normally doctors won't say they've cured an incurable disease such as sickle-cell Anemia, but they're coming close to saying it about two Atlanta-area children. The boys, ages 5 and 12, recently received bone marrow transplants and have been declared disease free, say doctors at Emory's bone marrow transplant program. The children are the first patients in Georgia and among fewer than 30 worldwide to undergo a bone marrow transplant to treat sickle-cell anemia. Seventy to eighty percent of the patients who have undergone transplants have been cured. One of the two children, Seye Arise, now goes to school, plays ball and giggles uncontrollably like any other 5 year old. But he can remember how it was before his operation last November when he received bone marrow from his older brother. "Everything hurted," he said. Seye suffered a mild stroke and was

at risk for having more strokes. In the bone marrow replacement his faulty gene was replaced with a normal gene.

The second patient, 12-year-old Roger Johnson, received marrow from his older sister in April.

Researchers are hoping that with the dawn of gene therapy, it will be possible to correct a child's faulty gene without having to find a donor with a matching bone marrow. Doctors someday may be able to remove a patient's own marrow, insert a normal gene and put the marrow back, a treatment that would be applicable to a much larger percentage of patients. However, that's at least a decade away.

Sickle-cell disease is a generic term applied to a group of genetic disorders characterized by the production of abnormal hemoglobin molecules (Galloway & Harwood-Nuss, 1988). While normal blood cells are oval or round in shape, the red bloods cells of those with the disease are sickled in shape and vascular occlusion occurs when sickled red blood cells create blockages in the capillaries (Galloway & Harwood-Nuss, 1988). The disease primarily affects African Americans and current estimates indicate that one out of every 600 African American infants is born with the disease (Sickle-Cell Disease Association, 2000).

In 1974 states began screening infants for sickle-cell disease and currently 40 states make testing a routine part of their infant screening procedures (Sickle-Cell Disease Association, 2000). Screening is usually conducted on the third day after birth or on the day of scheduled discharge from the hospital. Three possible diagnoses can be made. The first is absence of the sickle-cell disease or sickle-cell traits. The second is a diagnosis of the sickle-cell disease. An infant will inherit the disease only if the gene has been inherited from both parents. The third diagnosis occurs when the newborn inherits only the genetic traits but not the manifestation of the disease from the parents. There appear to be two forms of this third trait; Sickle C Disease and Sickle Thalassemia. Neither of these two forms are severe enough to cause the pain, the discomfort, and the mortality associated with the actual disease.

Sickle-cell anemia is a lifelong disease with no known cure. Although there have been reports of death under the age of 2 (primarily caused by bacterial infections, acute splenic or sequestration crises), many with the disease often live into middle age.

One of the most serious complications of sickle-cell anemia is stroke. Statistically, about 11% of children affected with sickle-cell anemia experience strokes, which can lead to lasting disabilities.

If the diagnosis of the disease is not made at birth, most parents discover that their child has sickle-cell anemia within the first 2 years of life (Lukens, 1981). The common symptoms that parents report their children displaying include anemia, fatigue, bacterial infections, strokes, kidney dysfunction, and chronic pain in the arms, legs, back, and abdomen.

The onset and duration of the pain episodes are variable and often unpredictable. These episodes can last from one hour to several hours or days.

Although the pain of sickle-cell anemia is the most difficult to bear, the adjustment to the disease appears to be problematic for both the children and their families.

It seems that sickle-cell anemia affects family functioning in a number of ways (Armstrong, Lemanek, Pegelow, Gonzalez, & Martinez, 1993). First, the disease appears to have a negative impact on parental marital relations. In one reported case study, marital stress increased and communication decreased. Both parents expressed guilt, depression, and anxiety about their role in the child's illness. Furthermore, single mothers report feeling overwhelmed by the demands of the disease and report having more negative feelings about their children as well as being more overprotective than do intact families. Second, the disease has an impact on the child's self-esteem, peer relationships, and academic functioning. Children with sickle-cell anemia have higher levels of chronic anxiety as compared to a healthy control group of their peers (Gil et al., 1991). They tend to be excluded from peer group activities and have difficulty in developing friendships because of their frequent hospitalizations. There is some evidence suggesting that these children are less successful in school than their healthy age-mates.

Treatment of Sickle-Cell Anemia

If the pain episodes of the disease are severe, hospitalization is a common outcome. Once hospitalized, the child receives analgesics, penicillin, and fluids (to prevent dehydration).

Currently two types of medical treatments are available, both of which are new approaches and quite experimental. One treatment, as discussed in the Insider's Voice, is the bone marrow transplantation treatment. The other, which is primarily available for adults but is also currently being administered to infants and young children, is Hydroxyurea, a chemotherapy drug. Although there have been mixed results (i.e., patients have reported a significant decrease in the onset and severity of pain episodes), researchers caution that the drug is not a "cure all" for infants and young children (Powars, 2001).

To assist parents with medical management and other psychosocial issues there are several support groups available throughout the United States.

Depending on the needs of the family, these groups can function primarily as an information and referral service for the family or provide them with information on therapy and more structured support services (Armstrong et al., 1993).

There is also a national organization called the Sickle-Cell Anemia Disease Association, which serves as a clearinghouse offering information to parents and those affected with the disease on the available local and regional medical, social, and outreach services in their area (visit their website at www.sicklecelldisease.org).

The Sickle-Cell Anemia Disease Association's primary goals for the new millennium include increasing the number of states that screen for the disease in infancy, providing genetic counseling to African American parents, and targeting support services to single parent households as its.

St. Jude Children's Research Hospital is currently studying various treatment modalities for African American children who are suffering from sickle -cell anemia. In addition to conducting clinical trials for effective drug and nutrition approaches, they serve as a clearinghouse for dissemination of contemporary information on sickle-cell anemia for parents, and they provide respite care and counseling for both children and their families (Ware, 2004).

Asthma

Asthma is the most common chronic illness of childhood (Wettzman, Gortmaker, Sobol, & Perrin, 1992). The number of children diagnosed with moderate to severe asthma has increased in the past several decades and unfortunately; a disproportionate number of these children are African American (National Asthma Association, 2003; see www.lungusa.org for more information).

Presently there are 4.8 million children under the age of 18 diagnosed with asthma (American Lung Association, 2004).

The incidence of asthma is 22% higher in African American school age children than in their White counterparts and is especially prevalent in inner city African American children (Sin, Kang, & Weaver, 2005, see Figure 3.5).

According to experts, this is due to such environmental risk factors such as pollution, cockroaches, cigarette smoke, and inadequate access to health care (Izierieta et al., 2000).

African American children who suffer from severe asthma are more likely to miss school, experience frequent hospitalizations, and suffer from severe disability. They are also 4 to 6 times more likely to die from asthma than are their White age mates (Lozano, Connell, & Koepsell, 1995). African American children have an annual rate of hospitalization of 74 per 10,000 compared to

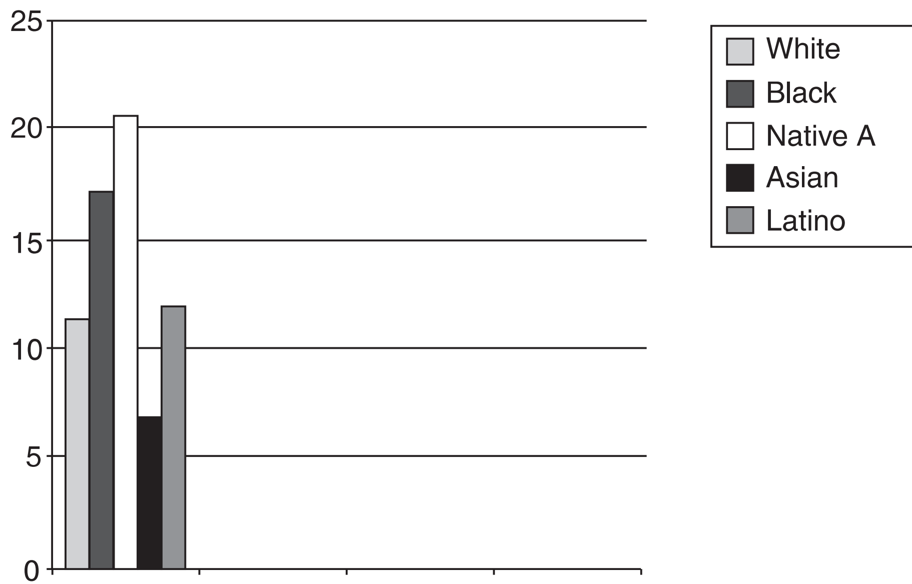


FIGURE 3.5 Asthma incidence among children under 18 by race.
Source: National Asthma Association (2003).

21 per 10,000 for White children (see National Asthma Association Web site for more information, www.lungusa.org).

Treatment of Asthma

Asthma is treated by one of two methods. One method involves the administration of anti-inflammatory agents, and the other involves the use of bronchodilators (Celand, Geller, Phillips, & Ziman, 1998). However, little information is available documenting the most effective treatment modality for African American children.

The research that exists on African American children and asthma has taken one of two foci. One focus is on school-based medical management of asthma. McEwen, Johnson, Neathelin, Millard, and Lawrence (1998) found that school-based programs which provide medication during school hours may be one way to increase the medication use, and indirectly decrease morbidity rates, emergency room visits, and the frequency of hospitalizations. They speculate that with direct and consistent supervision African American children may comply with a medication schedule.

The other body of research has focused on assessing parental knowledge and attitudes about asthma including knowledge of prevention and treatment issues. Koening and Chesla (2002) found that the majority of parents in their study were aware of asthma triggers, employed a variety of medical management strategies and used several prevention strategies; however, they were

dissatisfied with medical restrictions and high cost of asthma treatments, even with co-pays. Similarly, Peterson, Sterling and Stout (2002) observed that parents were knowledgeable about the causes of asthma as well as treatment approaches.

Community-based outreach, which targets African American children with asthma, have been implemented across the United States. For example, in Seattle, Washington, a group of health care officials and school officials have created information, referral, and treatment services for African American children (National Asthma Association, 2003; Web site www.lungusa.org).

Obesity

Obesity among U.S. school age children has increased in the last 25 years (Davy, Harrell, Stewart, & King, 2004). As a result, medical practitioners as well as social policy advocates and politicians have identified this issue as a national concern for the beginning of the 21st century (Future of Children, 2006).

African American children are more likely than their White counterparts to be classified as obese during the school age period and well into adolescence. As Figure 3.6 indicates, the body mass index (BMI) for African American male and female children from ages 6 to 11 is double that of their White peers.

It seems that the health consequences of obesity are more severe for African American children than children from other racial and ethnic backgrounds. Davis (2003) found that African American children who ranked in the 95th

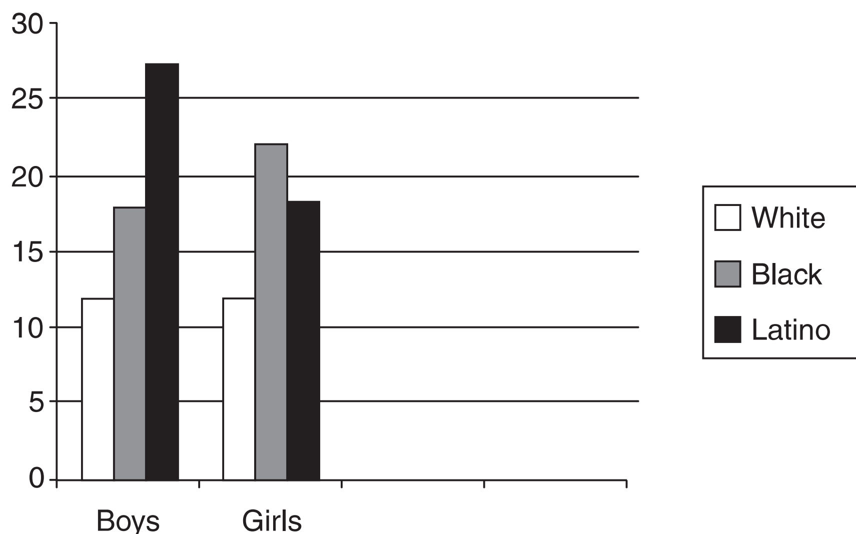


FIGURE 3.6 Body mass index comparisons.
Source: Center for Disease Control and Prevention (2006).

percentile on BMI measures were at risk for such health complications as hypertension, respiratory problems, and diabetes.

Causes identified in the scientific literature range from genetics to lifestyle issues. That is, scientists state that African American children inherit a biological predisposition to obesity as a result of parental obesity (Kumanyika & Grier, 2006). Others maintain that environmental factors such as a sedentary lifestyle, cultural preferences for food, and unsafe neighborhoods and poverty are the major contributing factors to obesity in African American children. Kumanyika (2006) expands upon the environmental contribution theory and states that the limited availability of health foods and healthy foods in urban areas constrain the types of meals and nutrition available to African American children and their families. Furthermore, coupled with environmental risk factors (i.e., neighborhoods with high crime rates), the rise of obesity rates in African American children is difficult to fight.

Treatment of Obesity

A variety of treatment approaches have been proposed. Those approaches involve dietary modifications (Shield, 2006), and increasing exercise level (Fitzgibbon, 2005). However, as Kumanyika (2006) suggests, prevention and intervention efforts for low income African American children and their families residing in urban areas may need to differ to take into account their environmental challenges and ecologies.

SECTION TWO: ACCESS TO HEALTH CARE

Having access to health care, including health care insurance and availability of a medical home, is critical in preventing, treating and managing the health challenges described in the previous section of the chapter.

According to the public health literature, African American children who lack health insurance are less likely than children with public or private insurance to visit a physician on a regular basis, less likely to have a personal physician and receive preventive services, such as routine pediatric visits, dental visits and eye exams, and more likely to use outpatient clinics and emergency rooms (Sochalski & Villarruel, 1999). Consequently, minor and acute health problems can go untreated and eventually become serious and chronic health conditions.

Fortunately, health care initiatives implemented in the past 20 years at the federal and state level have been effective in providing health care insurance for poor African American children. For example, in 1965 President Lyndon B.

Johnson established the federal program of Medicaid as a part of his war on poverty. This program provides health care insurance for the disabled, the elderly, and for single women and their children. Medicaid covers a range of services, which includes inpatient and outpatient care, periodic health check-ups, and diagnosis and treatment of health problems. Medicaid covers approximately 14,486,000 children, and African American children comprise 40% of these children (U.S. Census Bureau, 2000). At the state level, there is the Child Health Insurance Program (CHIP), implemented in 1998, and Healthy Baby/Healthy Start implemented in 2000 (Jenkins & Faulk, 2002). Both provide health care coverage to low income children and Healthy Baby/Healthy Start offers physician referrals and other health and medical support services to poor families and their children.

Despite the federal and state level initiatives designed to provide health care coverage for poor African American children, racial disparities remain in the prevalence of certain medical conditions (Copeland, 2005). It seems that "having access to health insurance does not necessarily improve the quality of life and the overall health/well-being of African American children alone" (Cooper, 2005). Public health scholars argue that the disparities continue to exist because African American children are more likely than other children to underutilize medical services (Alio & Salihu, 2005). The reasons identified in the literature are quite diverse and range from parental attitudes and knowledge about health and well-being; structural barriers which include financial and transportation issues; to parental perceptions about the quality of medical treatment (Copeland, 2005).

What solutions have been offered and what models have been proposed to eliminate the barriers? Some national level and community level initiatives are listed in Table 3.2.

TABLE 3.2 Initiatives to Improve the Health Status of African American Children

National level	Community level
1. Inclusion of more AA children in health care research and clinical trials.	1. Increase the number of church-based health initiatives.
2. Increase funding for research on the health conditions of African American children.	2. Increase the number of health education programs located in the African American community.
3. Make health care practitioners aware of the unique challenges in the African American community.	3. Use African American community groups, fraternities and sororities as outreach vehicles.

Source: Center on Budget and Policy Priorities, 2000.

The initiatives at the national level primarily focus on improving the quality of health care for African American children by: (1) Involving African American children in medical research. African American children are rarely included in clinical trials. Consequently, there is little information available on the etiology, most effective treatment methods, and course of illnesses in African American children, or the environmental variables that might facilitate or constrain their use of medication. (2) Informing health care practitioners of the unique challenges present in the African American community. Many health care practitioners have had minimal contact with the African American culture and cannot comprehend the impact of poverty and race on such issues as health care and attitudes. (3) Increasing funding for research on health conditions that mainly affect African American children. As a result of federal funding, advances have been made in the diagnosis and treatment of sickle-cell anemia.

Currently, public health practitioners are advocating for incorporating courses that emphasize the influence of culture on health attitudes and behaviors in medical service provider coursework (Betancourt et al., 2003). In addition to this approach others have proposed a multipronged approach involving an increase in the diversity of the health care workforce to ensure that the health care workforce is reflective and representative of its patient population, along with initiating on-going cross-cultural training to health care service providers (Perloff, 2006). Horn and Beal (2004) suggest that there should be an increase in child health disparities research, which includes systematic investigations exploring the root causes of child health disparities, with the ultimate goal of developing effective intervention programs targeting families, the health system, community, and society.

The community level initiatives focus on using community groups, fraternal organizations, and churches as places to disseminate information about health insurance and health care issues to African American children and their families.

In addition to the initiatives outlined in the box, the Council on African American Affairs, a policy research organization located in Washington, DC, has identified the area of African American children and health care as one of their major policy issues for this millennium. Their primary objective is to develop strategies to eliminate the health care disparities for African American children.

PERSPECTIVES ON THE HEALTH STATUS OF AFRICAN AMERICAN CHILDREN

While there has been an increase in the number of African American mothers receiving prenatal care, the infant mortality rates for African American infants,

although decreasing, still remain higher than the national average. Seemingly, the myriad of programs designed to target this population of mothers is meeting with minimal success. Why are these initiatives not producing significant changes in the infant mortality rates in the African American community? Is it the quality of prenatal care that mothers receive that place them at a higher risk for birthing an infant who will die within the first year of life? Or are there other environmental variables that need to be identified through systematic and rigorous investigations that might be associated with maternal behavior and prenatal and neonatal outcomes? Future research should focus on understanding why this problem persists.

AIDS and asthma disproportionately affect African American children. Are African American mothers aware of the drug treatment options, and are they offered the drug treatment options that reduce the chances of mother-to-child transmission? The morbidity rate for African American children from asthma is disquieting given the availability of treatment for the disease. This issue underscores the need for research that explores the causal factors for asthma and African American children.

Access to health care continues to be a pressing problem for many poor African American children. Implementing the initiatives stated in the chapter is a first step in improving access to health care and improving the health status of African American children.

CHAPTER SUMMARY

In this chapter, we have highlighted various aspects of physical development, and specific challenges and problems faced by the African American child. Some of these problems, such as lead poisoning and prenatal drug exposure, can have long-term effects beyond physical development.

The problem of infant mortality is overwhelmingly cited as a cultural problem. Higher infant mortality rates are evident in births to African American mothers living in high poverty areas in the East North Central Region of the United States.

Low birth weight and prematurity of infants are cited as causes of high infant mortality rates within the African American community.

Several biological and environmental factors contribute to low birth weight and prematurity and the increased incidence of infant mortality within the African American community. These factors, referred to as maternal risk factors, are maternal age, maternal SES, maternal health, maternal drug use, and maternal prenatal care.

Young mothers, poor mothers, mothers experiencing health problems, mothers abusing such drugs as cocaine and alcohol, and mothers receiving less than adequate prenatal care are at risk for giving birth to low birth weight and premature infants.

One major health concern within the African American community is AIDS. Mothers infected with the virus have a 30% chance of birthing infected infants. These infected infants experience several medical complications and do not live long after birth.

Several federal and state programs are targeting the problems that women face in receiving inadequate prenatal care. Programs currently implemented include WIC, Health Baby/Healthy Start, and Home Visiting Programs.

Lead poisoning, sickle-cell anemia, and asthma are three health problems that greatly impact the physical development of African American preschool and school age children. Exposure to lead poisoning comes from the paint used in the interior of older and dilapidated homes mostly located in the lead belt regions of the United States. The results of exposure to lead poisoning include physical, behavioral, and cognitive problem. Current treatment involves the administration of drugs that remove the lead from the body. Sickle-cell anemia is a blood disorder with no known cure. Diagnosis is usually made at birth and the symptoms include anemia, infection and chronic pain. Medical management involves analgesics, penicillin, and a couple of experimental procedures. Asthma, a current health problem for many school age children, disproportionately affects African American children. In comparison to their age-mates from other racial groups African American children are more likely to experience severe asthma. Little is known about the type of treatment that is most effective in managing the symptoms of asthma for African American children. However, one promising approach is school-based management and distribution of medication.

Access to health care is one way to prevent and treat the illnesses discussed in the chapter; however, many poor African American children are uninsured or underinsured. There are initiatives, both at the federal level and the community level, designed to address health care issues for African American children.

ADDITIONAL READINGS

Infant Mortality

Battle, R. S., Cummings, G. L., Barker, J. C., & Krasnovsky, F. M. (1995). Accessing an understudied population in behavioral HIV/AIDS research: Low income African American women. *Journal of Health and Social Policy,* 7, 1–18.

Foster, H., Wu, L., Bracker, M., Semenya, K., & Thomas, J. (2000). *Journal of the National Medical Association, 92*, 213–221.

Lia-Hoagberg, B. (1990). Barriers and motivators to prenatal care among low-income women. *Social Science Medicine, 30*, 487–495.

Sanders, K., & Davis, S. (1998). Improving prenatal care for low-income African American women and infants. *Journal of Health Care for the Poor and Underserved, 9*, 14–29.

York, R., Tulman, L., & Brown, K. (2000). Postnatal care in low-income urban African American women: Relationship to level of prenatal care sought. *Journal of Perinatology, 1*, 34–40.

Health Issues

Cornelius, L. J. (1993). Barriers to medical care for White, Black and Hispanic children. *Journal of the National Medical Association, 85*, 281–288.

McEwen, M., Johnson, P., Neatherlin, J., Millard, W., & Lawrence, G. (1998). School based management of chronic asthma among inner city African American school children in Dallas Texas. *Journal of School Health, 68*, 197–200.

Minority Coalition of the United Food and Commercial Workers Union (producers). (2000). Sickle-cell disease: The faces of our children. Videotape. Available from Fanlight Productions, 4196 Washington Street, Suite 2, Boston, MA, 02131.

Rand, C. S., Butz, A. M., Kolodner, K., Huss, K., & Malveaux, F. (2000). Emergency department visits by urban African American children with asthma. *Asthma and Immunology, 105*, 575–582.

CHAPTER 4

Mental Health Issues and Racial Identity

OVERVIEW

The paucity of research available concerning African American children is a reoccurring subject throughout this book, and this becomes even more evident when discussing mental health issues and African American children. There are few comprehensive studies describing the onset, etiology, and treatment of mental health disorders in African American children. This seems puzzling given that African American children are identified in the social science literature as being the most at-risk group of children and they encounter a myriad of environmental and psychosocial stressors that contribute to their poor mental health functioning.

This chapter is divided into two sections. Section one begins with a discussion of the risk factors that predispose African American children to mental health problems. The section continues with a discussion of the problems in misdiagnosing disorders in African American children. The section concludes with a discussion of the various psychotherapy interventions used with African American children.

Section two discusses racial identity development in African American children with specific attention paid to the theoretical perspectives and research on racial identity development. The chapter concludes with a discussion of Perspectives on Mental Health Issues and Racial Identity.

SECTION ONE: MENTAL HEALTH ISSUES

INSIDER'S VOICE: AFRICAN AMERICAN CHILDREN AND MENTAL HEALTH ISSUES

1. In comparison to their White counterparts, low income African American children report experiencing higher test anxiety.
2. There is evidence to suggest that a very large percentage of African American children are at risk for clinical depression during childhood.
3. African American children are over reported as psychotic.
4. As many as 3% of African American children between the ages of 10 and 11 are diagnosed with behavior and conduct disorders.
5. A significant proportion of referrals for elementary school African American children are for academic and behavioral problems.
6. African American children are five times more likely than White children to be referred to a psychiatric facility or recommended for incarceration.

Source: Allen & Majidi-Ahi, 1988

Risk Factors

Why are African American children experiencing these disorders at higher rates than White children, and what factors are involved in making them more or less vulnerable to negative and adverse mental health outcomes?

An interaction of biological, environmental, and socio-historical factors place African American children at higher risk for the psychological impairments described in the Insider's Voice (Liaw & Brooks-Gunn, 1994).

Those biological risk factors include their birth status (e.g. low birth weight), and other childhood illnesses discussed in chapter 3. Environmental risk factors include poverty, and family constellation. African American children living in poor single-mother-headed households exhibit more symptoms of depression than those reared in two-parent family homes (Barbarin, 1993). In addition to those factors, African American children who live in families with a history of mental illness, who experience multiple moves, experience homelessness, and live in violent neighborhoods, are at a high risk for the adverse mental health outcomes discussed in the Insider's Voice (Dawson, 1991).

It seems to be when the risk factors are cumulative and persistent, the incidence of depression and other mental health problems increase and rarely abate in adolescence for some African American children (Sameroff, Seifer, Baldwin, & Baldwin, 1993).

The popular literature abounds with examples of African Americans who as children encountered difficult life circumstances, yet who were able to develop the coping strategies and survival skills that would buffer the impact of negative life circumstances.

Why and how poor children in general and African American children in particular are able to overcome the odds and prosper as adults has been the focus of research for the past three decades (Cicchetti & Garmezy, 1993). In particular, the research has addressed the basic question "what makes some children resilient in spite of their environment?" The body of literature on resiliency has identified both personal and environmental factors that are integral in overcoming the odds. One factor is temperament; children who overcome the odds are characterized as having an easygoing and flexible temperament (Garmezy, 1983). Another factor is self-esteem; children who achieve in spite of their circumstances have high self-esteem and self-efficacy. In addition to these two factors, studies show that there needs to be some external support for developing good mental health. These supports include social support—either from a teacher, a minister or through an organization (e.g., Big Brother/Big Sister); and role models (see Zimmerman, & Arunkumar, 1994 for a full discussion of resiliency models). Figure 4.1 presents a resiliency model.

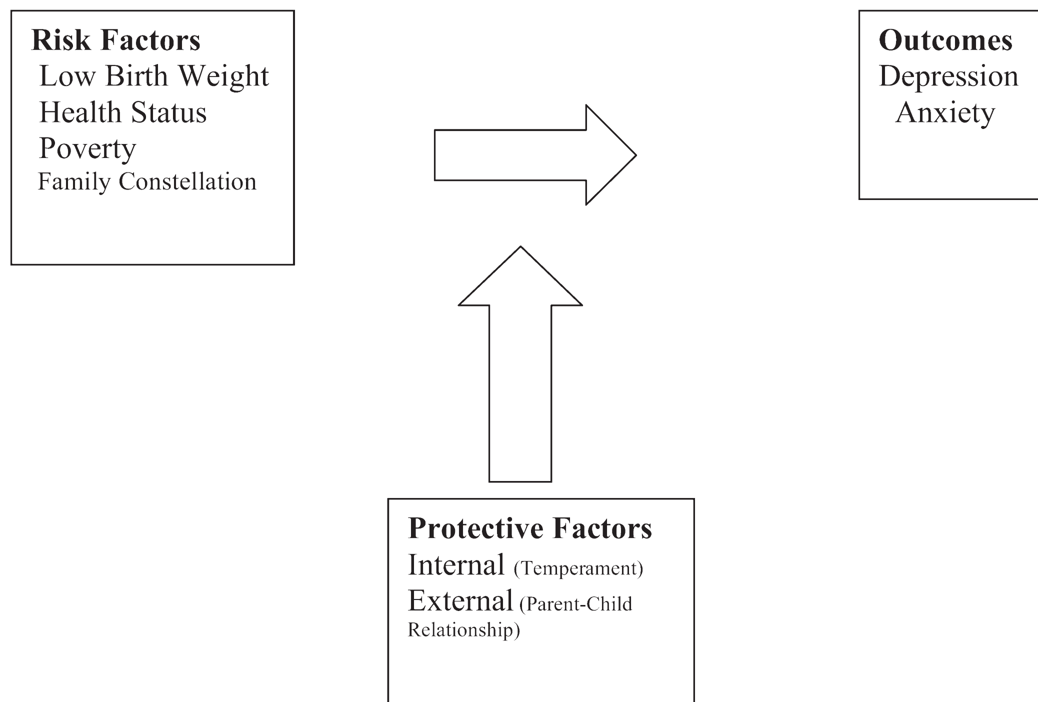


FIGURE 4.1 Resiliency model.
Source: Zimmerman & Arunkumar, 1994.

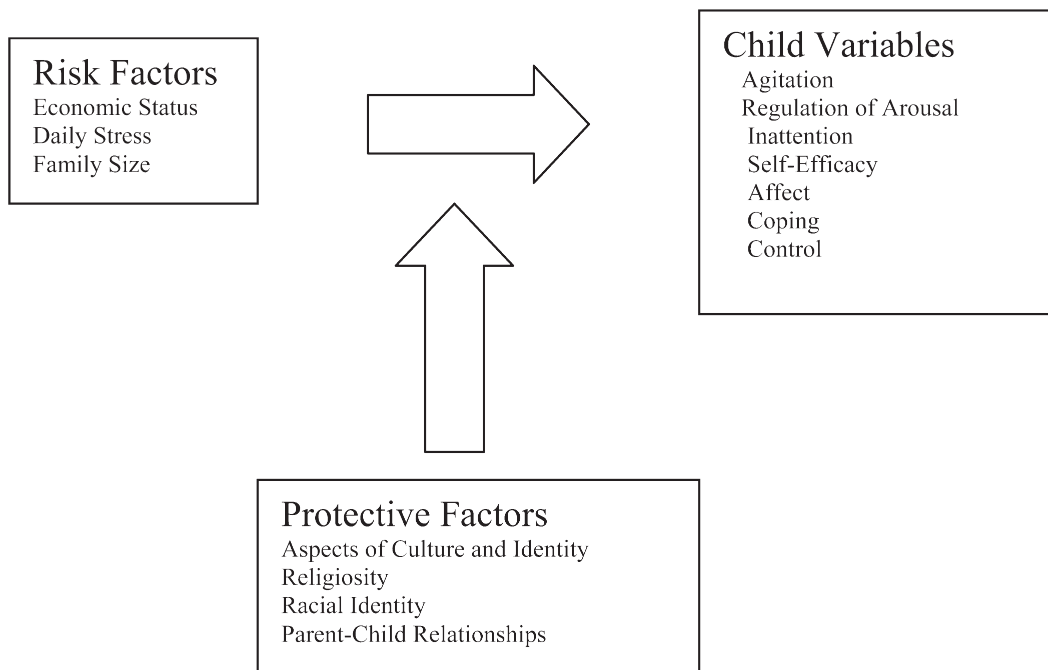


FIGURE 4.2 Barbarin's resiliency model.
Source: Barbarin, 1993.

Barbarin (1993) offers an alternative resiliency model for African American children. He argues that there is a need for such a model because little is known about the nature of the conditions that enable African American children to resist adverse circumstances. His model is presented in Figure 4.2.

The core features of his model include similar risk factors and protective factors listed in Figure 4.2, but he has expanded his model to take account of additional protective factors, such as family religiosity and racial socialization. Depending on the role they play in the caregiver's lives, these factors ultimately serve to protect African American children from adverse mental health outcomes.

Assessment and Diagnosis

For the past few decades, social scientists have voiced their concerns about the accuracy and validity of the methods and procedures used to assess and diagnose mental health disorders in African American children (Jones, 1988). They argue that the overrepresentation of African American children in certain diagnostic categories is due primarily to misdiagnosis.

Assessing mental health disorders is done through clinical interviews and the administration of personality and behavioral measures (Brems, 2004). Frequently, assessment, especially for African American children, is conducted without obtaining important environmental and social information. As a remedy,

Gopaul-McNicol et al. (1995) recommends that assessment be augmented with the inclusion of the following information: Physical appearance—an assessment of the child's physical appearance provides information on health status, affect and emotional functioning; intrapersonal issues—elicit information from the children about feelings of self-worth and value, as well as their coping mechanisms; interpersonal relationships—obtain information about peer group, and friendship relationships; family dynamics—prior to conducting the assessment it is vital to obtain information about the family system and to identify the family structure, as well as the family's attitude about mental health (e.g., what is the family's traditional pattern of help seeking). Furthermore, given the current estimates of the number of children born to parents of African descent immigrating to the United States, information on immigration history and the child's level of acculturation should be obtained. An example of a culturally relevant assessment instrument is presented in Box 4.1.

BOX 4.1

A Culturally Relevant Assessment and Diagnostic Tool

Bidaunt-Russel, Valla, Thomas, Bergeron, and Lawson (1998) have developed an alternative method to assess and diagnose mental disorders in African American children. Their instrument, developed in 1981, called the Terry, is an orally administered assessment. Children are presented with pictures of Terry engaged either alone, with peers or adults, in a variety of social situations. Children are asked to respond to questions (e.g. have you ever destroyed other people's things on purpose like Terry?).

According to the authors, such diagnosis as: Depression, Dysthymia, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Separation Anxiety Disorder, Overanxious Disorder, and Simple Phobia can be made based on the children's responses. There is also a parent component. Parents are given similar stimulus cards and asked if Terry's behavior represents the behavior of their child.

The Diagnostic and Statistical Manual (DSM-IV) is the standard manual used by clinicians to determine mental health disorders in children and adults. The DSM-IV is a multiaxial coding system that allows the clinician to rate mental health functioning according to five axes (DSM-IV, 2000). The diagnostic categories have been derived from research conducted on White populations.

Its effectiveness as a diagnostic tool for African Americans in general and African American children in particular has been a subject of controversy

for many decades. The major argument is that the DSM-IV fails to take into account the cultural, socio-political, and environmental influences that contribute to the mental health functioning of African American children (Spencer, Kohn, & Woods, 1998).

There is evidence to suggest that there are differences in how individuals from different cultures experience and express symptoms of mental illness. Furthermore, the patterns of onset, duration, and the clustering of specific symptoms vary widely across cultures (Costello et al., 1996). Finally, not all expressions of mental health disorders are universal. Clinician error is also highly probable. The majority of the clinicians responsible for diagnosing disorders are White and have had little experience and training in working with African American children and their families (Neighbors, 1998).

In 1994, the American Psychological Association adopted a policy on culture and diagnosis (APA, 1994). An excerpt of the follows:

> Caution should be exercised in using the DSM with people from different cultural or ethnic groups. It is important that the clinician not employ DSM in a mechanical fashion, insensitive to differences in language, values, behavioral norms, and idiomatic expressions of distress. The clinician working in such a setting should apply DSM with open mindedness to the presence of distinctive cultural patterns and sensitivity to the possibility of unintended bias because of such differences. . . . The DSM is not based on extensive research with non-Western populations.

However, according to Johnson (1993) the policy is too vague and does not provide specific guidelines on obtaining critical information to make an accurate diagnosis.

As an alternative Johnson has proposed expanding and revising the DSM-IV to include an additional axis, called the Psychocultural Adaptive Functioning (PAF). This axis could be used to diagnosis the cultural functioning of the child as well as determine the child's coping strategies, family and environmental support. The PAF also provides detailed information on the person's racial self-esteem, locus of control, community support, family psychological availability, and cross cultural competency and allows the clinician to place the disorder in the context under which it occurs. Johnson believes that the PAF axis will ultimately lead to accurate diagnosis and effective treatment plans. He offers guidelines for evaluating and diagnosing African American children (see Box 4.2 for his guidelines).

Treatment of Mental Health Disorders

Historically, African American children and their families have underutilized mental health services (Davis & Ford, 2004). Researchers have identified a variety of internal and external barriers, which contribute to their underutilization. The internal barriers include myths, attitudes, and beliefs

BOX 4.2

Guidelines for Diagnosing African American Children

1. Each step in the diagnostic process should include acknowledgement of the role that values, beliefs and practices of the African American culture attach to psychopathology.
2. Clinicians should inform patients (parents) of their right to challenge and question the diagnosis offered.
3. The Association of Black Psychology, APA, and state licensing boards should work together to assure integration of an Afrocentric perspective into graduate training programs.
4. Consultation with a senior clinician skilled in diagnosis and treatment of African Americans is critical.
5. The clinician's diagnostic hypotheses should always prompt a series of questions so that the patient responds only with symptoms relevant to the hypothesis. The hypotheses and questions must elicit Afrocentrically related diagnostic issues.

Source: Johnson (1993)

about seeking mental health treatment (Snowden, 2001) and the external barriers include the economic and accessibility issues discussed in chapter 3 (e.g., limited access to mental health treatment facilities, lack of health insurance) as well as attitudes and negative interactions with mental health professionals (Hines-Martin, Malone, Kim, & Brown-Piper, 2003).

African American children are treated differently in terms of therapeutic approaches. African American children are less likely than their White counterparts to be referred for individual therapy. Rather, they are more likely to be recommended for group or peer counseling. There is ample evidence to suggest that African American children do benefit from individual counseling (Boyd-Franklin, 1989)

Allen and Majidi-Ahi (1989) suggests that therapists working with African American children and their families approach therapy from a social ecological perspective. This perspective entails an awareness of African American racial identity issues and the process of racial identity, language issues, as well as family dynamics.

Boyd-Franklin (1989) recommends that therapists working with African American children employ a multisystems approach. This approach involves including all members of the family, both nuclear and extended, who have a direct link to the child in the therapeutic process. Therapists working with

African American children and their families must expect to assume a variety of roles. Those roles may include serving as a mediator between the family and the school system or identifying and linking the family to the appropriate social service agencies.

Others working with African American children and their families have found cognitive, behavioral, and insight therapy to be effective forms of therapy (Spurlock, 1985).

Regardless of the type of therapy used, the most important factors for successful therapy are: (1) a willingness for the therapist to tailor therapy to the family's belief system and goals and; (2) an awareness of the influence of race, socio-economic status, culture, and environment on African American family functioning.

SECTION TWO: RACIAL IDENTITY

One major developmental task for African American children is the development of racial identity (Spencer, 1982). A strong racial identity is considered to be an important buffer against those racial experiences and a critical aspect of parental racial socialization behavior.

At what age do African American children begin to notice racial differences, particularly their own differences? How does this awareness affect their self-esteem? What role do parents play in socializing African American children? Just how the process of racial identity occurs has been the subject of research dating back to the1930s.

The initial investigations examining the development of racial identity in African American children were conducted by several researchers (Horowitz, 1939), but Kenneth Clark and Mamie Clark (1939, 1947) were considered to be the leading experts on racial identity development and Black children (see the *American Psychologist* [2002] for a review of their contributions to the discipline of social psychology).

Theoretically, the Clarks believed that the self, a core part of the personality, (e.g., that is who we define ourselves as, what we believe and feel about ourselves) was in part determined by our identification with a group, and in part determined by our beliefs or feelings about the status of that group. According to the Clarks, as children engage in the process of acquiring group identification, and learn about the status of their group, they become aware of racial differences; they begin to develop racial preferences and to develop a personal racial identity. Based on this theory, the Clarks conducted a series of studies to assess the development of awareness of racial differences, to determine racial preferences and racial self-identification

in African American children. These studies were collectively referred to as the Doll Studies.

Two central findings emerged from their work. One, racial awareness is present in African American children as young as age 3; and two, the children consistently demonstrated a preference for the white doll in their responses. The later finding, according to the Clarks, may be an indication of "self-hatred." They believed that this early rejection of the colored doll was a reflection of the children's internalization of societal beliefs about the valence of being black and being white. According to the Clarks, "this struggle introduces early in the formation of the personality of these children a fundamental conflict about themselves" (see Figure 4.3).

The racial preference findings and the self-hatred hypothesis proposed by the Clarks sparked controversy and criticisms for more than five decades. The following problems were cited by social scientists. First, the validity of the measures to assess racial preferences and racial attitudes was questioned. Critics were doubtful that dolls alone would yield an accurate assessment of racial preferences and racial attitudes (Banks, 1976). Second, Banks, (1976) found in his reanalyzation of the earlier data that the children's responses conformed to simple chance responses. Thus the types of questions and the order of the presentation of the questions may have primed a response in the children. Third, Cross (1991) argues that the physical attributes and the novelty of the white doll may have contributed to the children's preference for the white doll over the black doll.

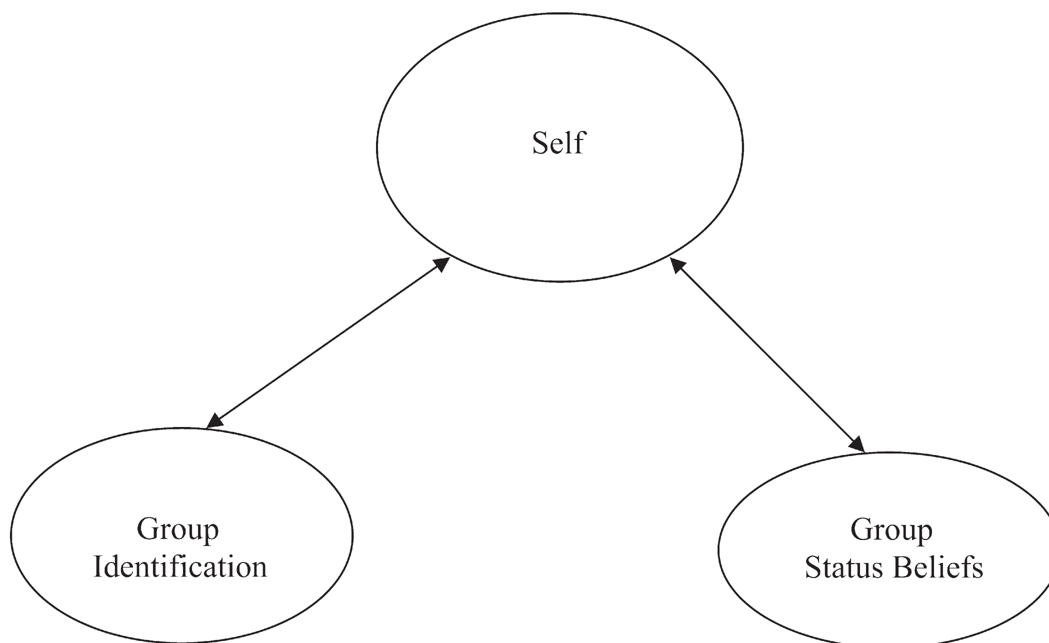


FIGURE 4.3 Racial identification model.
Source: Clark & Clark (1940).

The majority of the studies conducted since the Clarks' early investigations have examined racial preferences in African American children. These studies have spanned a 40-year period, and employed a variety of approaches to tap racial preferences. The data presented in Figure 4.4 represents a summary of the major preference findings of those studies.

As the figure indicates there was an overall increase in preference for the Black doll from 1950 to 1980. Many researchers have attributed the positive orientation to the Black doll as a result of sociopolitical movements (e.g. the Civil Rights Movement, the Black Power Movement), the positive portrayal of Blacks by the media, and the increase in the number of Black dolls available to African American children.

However, notice that the figure indicates a reversal in preference for the Black doll beginning in the 1980s. Researchers have had difficulty in interpreting this pattern, however one speculation is that the resurgence of racial intolerance that characterized the 1980s may have been a contributing factor and reflects internalized attitudes of the children.

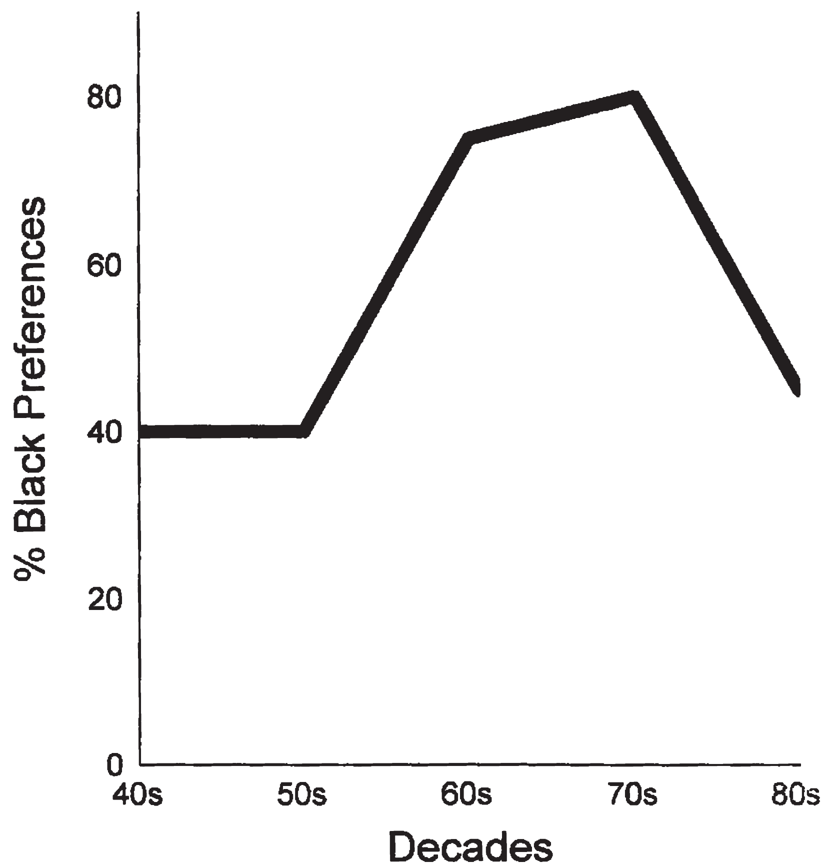


FIGURE 4.4 Racial preference study outcomes, 1940–1980.
Source: Banks (1976).

In the 1980s and the 1990s investigators took a different direction in exploring racial identification in African American children. The majority of those studies, although sparse, focused on such issues as modifying racial attitudes and racial preferences in African American children, assessing the relationship between self-concept and racial attitudes and racial preferences, and exploring cognitive models of racial identification.

Modifiability Studies. The goal of the modifiability studies was to determine if racial preferences could be changed by basic operant principles. Powell-Hopson and Hopson (1988) designed a two-phase study to test this idea. In the first phase of the study, 105 Black preschoolers and 50 White preschoolers were presented with dolls that were exactly alike except for skin color and hair texture and were asked preference questions: which doll do you want to be?; which doll do you like to play with?; which doll is a nice doll?; which doll looks bad?, which doll is a nice color?; which doll you would take home if you could?

At first, the majority of the children expressed an overwhelming preference for the white doll. The second phase of the study involved an intervention. In the intervention, the children were read a story depicting black children positively. The children were also asked to hold up the black dolls and repeat positive statements. After a 15 minute break, the children were re-administered the doll test. Posttest results indicated that the majority of the children demonstrated a preference for the black doll.

The researchers concluded that in a controlled environment, the racial attitudes of black children and white children could be modified. At some level children who incorporate negative societal messages about African Americans can be taught to change those attitudes. How these changes persist over time merits closer inspection.

Self-Concept and Racial Attitudes in African Americans. Is there a link between self-concept and racial orientation in African American children? McAdoo (1988) designed a longitudinal study to address the question. Using a methodology similar to the Clarks' to measure racial orientation, and several measures to tap self-concept, he followed a group of young children ages 3 through 6, for 5 years. His results indicated that the relationship between self-concept and racial attitudes remained statistically non-significant over the 5-year period. However, incidental findings revealed that the self-concept of these children increased over the 5 years, and their racial attitudes were initially moderately out-group oriented (e.g., they identified with a racial group other than their own) but became more in-group oriented over the 5-year period. McAdoo proposed the compartmentalization hypothesis to explain

the findings. This hypothesis suggests that Black children are able to feel good about themselves independent of their favorable perception of a racial group other than their own. Therefore their racial attitudes and preferences are a reflection of their ability to effectively compartmentalize racial issues and not a reflection of their self-concept.

Cognitive Level and Racial Attitudes. McAdoo's finding that the children moved from being out-group oriented to in-group oriented over a period of 5 years points to the need to explore how their thinking, their reasoning, and their understanding of the concept of race influences their racial preferences and attitudes. Various theorists have proposed cognitive focused models for several years (Spencer, 1982; Semaj, 1980).

These theorists maintain that African American children progress from lower to higher levels of thinking, reasoning, and understanding race. This progression of their cognitive level influences their racial preferences and attitudes. It is not until the children are able to decenter, and to conserve issues about race, that they are able to understand racial differences and to have racial preferences. The central features of the cognitive models are presented in Box 4.3.

BOX 4.3

Cognitive Model of Racial Identity Development

Stage	Characteristics
1. Racial Classification	understanding of racial differences
2. Racial Awareness	understanding that differences are limited to skin color, ability to categorize people by ethnic group
3. Racial Constancy/Stability	understanding that race is permanent
4. Racial Preferences	identification/attitudes

In addition to the cognitive factors identified above, researchers hypothesize that social and environmental factors either directly on indirectly influence the racial identity development (Marshall, 1994). Bronfenbrener's Ecological theory (1986) provides a useful framework for exploring those influences on the development of racial identity in African American children (an example of the model is presented in Box 4.4.).

Researchers have employed variants of his model to identify how social and environmental factors influence racial identity development (Dutton, Singer, & Devlin, 1998; Jaggers & Mock, 1993).

BOX 4.4

Ecological Model of Racial Identity Development

Level	Questions
Microsystem	How does the child's immediate environment influence racial identity development (e.g., parents, activities in the home, where the child lives)?
Mesosystem	As the child enters school (e.g., daycare) what experiences have an impact directly on the child's racial identity and what experiences have an impact on the parent's role or behavior in the development of the child's racial identity?
Exosystem	How do parental experiences with racial issues impact their parenting and their discussions about racial issues and racial identity?
Macrosystem	How has affirmative action/desegregation had an impact on racial identity development?
Chronosystem	How do political/societal changes impact racial identity? development?

Parents of African American children have the unique challenge of socializing their children to live a dual existence in society. That is, they must teach their children to recognize and embrace their relationship to a minority group as well as acknowledge their existence in a broader multiracial society. One particular childrearing task that parents must face is the task of racial socialization. Are there specific socialization practices and behaviors they use? The extant research on African American parents and racial socialization has increased in the past 40 years (see Hughes and Chen, 1997, for review). The research has addressed such questions as how and when do parents convey information about race to their children, what sort of information do they convey about race, and the context or situation that serves as a catalyst for discussions about race.

The conversations about race begin at an early age, around 6 or 7, the age at which most African American children have achieved a sense of racial identity. Peters (1988) found that the majority of the parents emphasize the following: (1) bicultural adaptation, (2) imparting the importance of self-respect and pride, (3) understanding the unfairness of others, (4) strong family ties, and (5) a positive orientation to one's ethnic group. Hughes and Chen (1997), on the other hand, observe that the content of those discussions can be classified into four areas: cultural socialization

(discussions about ancestry, culture, heritage), preparation for bias (awareness of discrimination, unfair treatment) socialization of mistrust (distrust of people of other racial groups), and egalitarian socialization (discussions about the value and importance of people from all racial backgrounds). Hot stove encounters (see Box 4.5 for an example of a Hot Stove encounter) frequently serve as the vehicle for those discussions about race (Daniel & Daniel, 1990). These encounters are described as overt and covert racial experiences, typically negative, which African American children encounter. These experiences are unexpected, and parents often have little control over when and where those encounters will occur. According to Daniel and Daniel, parents can equip their children with skills to cope with hot stove encounters by using a variety of parenting strategies such as modeling, and providing their children with survival messages (e.g., proverbs).

Television shows and the news also provide parents with teachable moments to discuss racial issues with their children.

Thornton et al. (1990) found that there is little consensus among African American parents regarding the importance of socializing their children about racial issues. For some, race is a central concern, so therefore they directly provide information to their children. For others, race plays an insignificant role in their socialization behaviors and goals. These parents state that they hesitate to discuss racial issues for the fear that their children will become bitter and resentful. In either case, mothers tend to be the primary socialization agents.

How do these parenting behaviors influence young children's beliefs, feelings, and behaviors about racial issues? The research examining outcomes is sparse, however, of the available literature the findings suggest that an overemphasis

BOX 4.5

"Hot Stove Experiences"

I can remember when I first learned that I was different—racially different that is. I was about five and I was attending Sunday school when this white boy called me a n________. I remember coming home and running up and down the hall in our home, shouting n________, n________, n________. My mother was appalled and demanded to know where I heard the word. From Sunday school I replied. From that day forward, I realized that I was different and that my parent's role in preparing me to deal with those who would not accept my difference as an African American had just begun.

on racial barriers and discrimination seem to undermine achievement and prevent the formation of interracial friendships (Christian & Barbarin, 2001; Ogbu, 1974). On the other hand, parents who chose not to provide their children with any information about racial issues leave their children with little protection (Caughy, O'Campo, Randolph, & Nickerson, 2002).

PERSPECTIVES ON MENTAL HEALTH AND RACIAL IDENTITY

If there is one area in child development that is in need of research it is the area of mental health issues and African American children. Epidemiological studies that describe the onset, duration, and characteristics of psychopathology for African American children are essential. In addition, research on effective assessment techniques, diagnostic tools, and therapeutic interventions is urgent. As discussed earlier in the chapter, some African American children are resilient and successfully emerge from the most difficult life circumstances. Barbarin's model is a first step in identifying culturally relevant protective factors. Thus, this model might prove useful for subsequent research. For example, such questions can be addressed as: do these protective factors change in their ability to buffer children?; and how do the children change developmentally?

The current consensus on the development of racial identity in African American children is that their identity development is facilitated by a host of social and environmental influences. Those influences include parents, relatives, peers, and teachers, and at some level, the media. Given that research has documented that a strong racial identity serves as a buffer against those hot stove experiences described in this chapter, subsequent investigations should focus on generating developmental models of racial identity development. Furthermore, those models should outline the relationship between different patterns of racial socialization, parenting behavior, and the psychosocial adjustment and psychosocial outcomes for African American children.

CHAPTER SUMMARY

The chapter presents an overview of the mental health status of African American children, with particular attention paid to the risk factors that predispose them to mental health problems. The chapter addresses the internal and external factors, which serve to buffer some African American children from severe mental health outcomes.

Assessment and diagnosis of mental health disorders continues to be problematic. At issue is the argument that African American children are more likely than their White counterparts to be misdiagnosed as a result of clinicians' lack of knowledge and subsequent inaccurate assessments or diagnoses. The procedures proposed by Gopaul-McNichol and Johnson are introduced. The former suggests augmenting assessment with additional behavioral, physical, and demographic information, while the latter suggests an additional axis be included in the DSM-IV.

The chapter also examines the available research concerning racial identity and African American children. An important developmental task for African American children is the development of racial identity. The chapter concludes with a discussion of the vintage research of the Clarks and introduces more contemporary views on racial identity development and African American children, along with information on parenting racial socialization practices.

ADDITIONAL READINGS

Racial Socialization

Caughey, N., O'Campo, F., Randolph, S. & Nickerson, K. (2002). The influence of racial socialization practices in the cognitive and behavioral competence of African American preschoolers. *Child Development, 73*, 1611–1625.

Hughes, D., & Chen, L. (1997). When and what parents tell children about race: An examination of race-related socialization among African American families. *Applied Developmental Science, 1*, 200–214.

Racial Identity Development

Tatum, B. (1997). *Why are all the Black Kids sitting together in the cafeteria? A psychologist explains the development of racial identity*. New York: Basic Books.

Mental Health and Resiliency Models

Barbarin, O. (1993). Emotional and social development of African American children. *Journal of Black Psychology, 19,* 381–390.

Horning, L., & Rouse, K. (2002). Resilience in preschoolers and toddlers from low-income families. *Early Childhood Education Journal, 29*, 155–159.

Spencer, M., Kohn, L., & Woods, J. (1998). Labeling vs. early identification: The dilemma of mental health service underutilization among low-income African American children. *Perspectives,* 1–14.

Assessment and Diagnosis

Johnson, R. (1993). Clinical issues in the use of the DSM with African American children: A diagnostic paradigm. *Journal of Black Psychology, 19*, 447–460.

Vargas, L., & Willis, D. (1994). Introduction to the special section: New directions in the treatment and assessment of ethnic minority children and adolescents. *Journal of Clinical Child Psychology, 23*, 2–4.

Treatment

Boyd-Franklin, N. (1989). *Black families in treatment*. Guilford: Boston.

CHAPTER 5

Education and African American Children

OVERVIEW

The education of African American children has consistently generated discussion and debate among educators, social scientists, the media, and the courts. One topic in particular, desegregation, has occupied the attention of the nation for more than 40 years. The educational experience of African American children, unlike the educational experiences of their counterparts from other ethnic groups, has had a long, complex, controversial political and legal history.

The goal of this chapter is to discuss those educational experiences and to discuss the factors that impact their educational progress. The chapter is divided into four sections.

The first section of the chapter, School Desegregation and African American Children, provides information about the landmark court decision *Brown v. the Board of Education,* which changed the course of education for children of all races in the 20th century. The second section of the chapter discusses African American children in the public school system, specifically highlighting their academic performance and identifying the factors that influence their academic achievement. The third section of the chapter presents early intervention programs and information on public and private schools that work for African American children. The chapter concludes with a discussion of perspectives on education and African American children.

SECTION ONE: SCHOOL DESEGREGATION AND AFRICAN AMERICAN CHILDREN

We begin with a discussion of desegregation, education and African American children.

INSIDER'S VOICE: RESEGREGATION OF AMERICA'S PUBLIC SCHOOLS

In January 2003, an article entitled "School Segregation Growing" written by Fredreka Schouten (Gannett News Service) appeared in the *Cincinnati Enquirer*. The article discusses a disturbing trend, the resegregation of America's urban public schools. According to Ms. Schouten, a study conducted by Harvard University professor Dr. Gary Orfield and colleagues, revealed that urban public schools are becoming increasingly segregated. During the 2000–2001 academic year, more than 70% of Black and Hispanic students attended minority schools. Dr. Orfield believes that this resegregation has resulted in creating a form of "educational apartheid." "These schools tend to have fewer qualified teachers, and the students are presented with less challenging course work than students in integrated suburban schools. The tragedy is that the resegregation of public schools is undermining the quality of education that minority students receive. The trend is going to produce a deeply unequal education and a more polarized society," Mr. Orfield said.

Desegregation and African American Children

The story reported in the Insider's Voice on school desegregation is one issue that has dominated the heart of national politics and educational policies for the past 50 years. The movement from segregated schools to desegregated schools and finally to resegregated schools has been an extensive and complicated movement.

In 1954, the United States Supreme Court ruled that school segregation was unconstitutional and that schools must begin to desegregate with all deliberate speed (Gardner & Miranda, 2001). This ruling was a result of a series of court cases challenging the separate but equal educational doctrine that had operated in the United States for more than 70 years.

Prior to 1954, African American children and White children, primarily in the southern region of the United States, attended legally segregated schools. Those schools were inferior in both physical structure and educational quality. Black students were taught with outdated textbooks, lacked transportation to schools, and their school buildings were inadequately maintained (Dentler, 1991).

A collective of African American parents, educators along with the National Association for the Advancement of Colored People (NAACP), initiated legal action in both local and federal courts to protest this disparity.

According to the plaintiffs, this substandard education contributed to feelings of inferiority, lowered self-esteem, and lowered self-concept in Black chil-

dren, and resulted in decreased occupational opportunities for them as adults (Irons, 1994).

On May 17, 1954, the United States Supreme Court ruled that school segregation in any form was illegal, racially identifiable schools must be eliminated and school districts must implement plans to desegregate their school districts. The legal case became known as the *Brown v. Board of Education of Topeka, Kansas* (see *Eyes on the Prize* for an excellent documentation of the case).

Resistance to school desegregation was widespread across the United States and efforts to stall desegregation were encouraged by state and local officials. In many parts of the United States, White parents and White citizens violently protested the entrance of Black students into schools. Federal troops were dispatched to provide protection for the students (e.g., Little Rock, Arkansas). It was not until passage of the 1964 Civil Rights Act that "sufficient movement was given to ensure progress in implementing the Court's ruling." The most consistent efforts to desegregate schools occurred between 1965 and 1973 (Fife, 1992). (See Box 5.1 for documentation on resistance to school desegregation).

Without specific directions and guidance from the courts, local school districts were left to develop their own desegregation plans. Those plans varied considerably from state to state and from school district to school district (Hayes, 1981).

BOX 5.1

Despite the 1954 *Brown* v. *Board of Education* ruling that required desegregation of public schools in America, one year after the decision most southern schools were still segregated and the quality of education offered to Black students was still far from equal to that offered to White students. In response, the Court ordered schools to integrate with all deliberate speed. With no definitive deadline, many states felt free to ignore the demand. In an effort to hold onto the long-standing tradition of segregation, many Whites joined the Ku Klux Klan and loosely organized groups called "White citizens councils" to terrorize and intimidate Blacks.

Chronology of Court Rulings and Efforts to Stall Desegregation

1954

The Supreme Court hands down the *Brown* v. *Board of Education* decision, stating that segregated school are inherently unequal, thus overturning the legal foundations of segregation.

School boards in Baltimore and Washington, DC, begin efforts to desegregate their systems.

1955

The Supreme Court, reacting to the slow pace of school desegregation following its *Brown v. Board of Education* decision, orders that school systems begin to integrate with all deliberate speed.

The Georgia Board of Education announces that it will revoke the license of any teacher who teaches in an integrated classroom.

1956

Three days after a Black woman named Autherine Lucy attends classes at the previously all-White University of Alabama, riots break out on campus, and threats are made on her life. In response, the school suspends Lucy. Following her court ordered re-instatement, the University expels her.

One hundred and one southern congressmen sign a "Southern Manifesto," recommending that public schools continue to ignore the Supreme Courts order to integrate. Only three members of the southern delegation to Congress—Estes Kefauver of Tennessee, Albert Gore, Sr., also of Tennessee, and Lyndon B. Johnson of Texas—refuse to sign.

1957

Governor Orville Faubus of Arkansas orders the Arkansas National Guard to block nine African American children from integrating the school. In response, President Dwight D. Eisenhower sends in paratroopers from the 101st Airborne to enforce the Supreme Court's ruling.

1961

Four high schools in Atlanta integrate without incident, earning the praise of President John F. Kennedy.

Administrators respond to student protests at Southern Louisiana University by shutting down the school.

1962

The Supreme Court orders the University of Mississippi to admit James Meredith as a student. Following a violent confrontation between White protestors and federal authorities, Meredith enters the school.

1963

Alabama governor George Wallace attempts to physically block Vivian Malone and James Hood from entering the University of Alabama.

1967

Ruling in *United States v. Jefferson County* that "the only school desegregation plan that meets constitutional standard is the one that works," the Fifth District of the U.S. Circuit Court helps speed the process of desegregation.

Source: African-American Experience on File

In the early 1960s, school districts opted to use freedom of choice and open enrollment as their desegregation efforts. Both of these methods were minimally effective in desegregating schools. At the urging of the courts, school districts turned to other methods such as pairing, rezoning, pupil placement laws, minority to majority enrollment, and reassignment from neighborhood schools via court ordered busing (see Fife, 1992 for a review).

Court-ordered busing, implemented in both the North and the South, was perhaps the most controversial facet of desegregation and caused negative and violent reactions from some parents across the nation (see Irons, 2002, for a discussion of the Finger Plan). Court-ordered busing was discontinued in the late 1970s.

During the 1980s, the desegregation process came to a standstill, and the courts ceased to monitor school districts and their compliance to the federal law.

For more than 30 years, scholars have debated whether desegregation has had a positive impact on the educational achievement of African American children. The research exploring this issue has yielded mixed results.

Systematic data collection did not begin until 1969, when the National Assessment of Educational Progress (NAEP) commissioned a study to examine the achievement test performance of African American children. From 1970 to 1984, 12 studies were conducted evaluating the impact of desegregation on the educational performance of African American children.

Few comprehensive studies have been conducted since the 1980s. Collectively, the findings from this body of research suggest two patterns: (1) Since 1971, the achievement test scores of African American elementary school children have steadily increased; and (2) despite this increase, African American elementary school children have lagged behind their White counterparts on all achievement measures by an average of 33 points (Garibaldi, 1997).

Some social scientists argue that it is difficult to determine the full impact of desegregation on the educational progress of African American children for the following reasons.

First, a decade after the *Brown v. Board of Education* judgment a significant proportion of African American students were still attending segregated

schools. As late as the 1972–1973 school year, 63% of the African American children attended predominantly Black schools, and these schools remained intellectually and structurally inferior (Gadsen, Smith & Jordan, 1996).

Second, 20 years after the court ruling, there was a 70% increase in the number of African American children attending segregated schools. Some scholars question whether desegregation was ever truly implemented and contend that increases in tests scores were not an outcome of desegregation (Vergon, 1990).

Third, the methodology in each of the studies conducted on achievement and desegregation vary significantly (e.g., different outcome measure, different time of measurement, different operational definitions of desegregation). Therefore, empirically it is difficult to formulate widespread and final conclusions about desegregation, African American children, and academic achievement.

Fourth, even though studies do indicate that the achievement gap has narrowed and that high school graduation rates and college enrollment have increased, the improvements affect only a very small percentage of African American students.

For the vast majority of African American students, desegregation has had a questionable or a detrimental influence on their educational process. Black students are more likely than their White counterparts to be expelled, suspended, or pushed out of school. Garabaldi and Bartley (1989) reported that in one school district, African American students comprised 41% of the school population, but 65% of those students were suspended. African American students are often placed in lower track courses or special education courses; as a whole, they take fewer foreign language courses, advanced math, or science courses, and therefore they are often unprepared to attend a four-year college or university. They are less likely than White students to participate in extracurricular activities, such as the marching band, the debate club, or other school-related activities. The nature and the quality of their classroom experiences differ from those of their White counterparts as well (Gadsen, 1996). Teachers have lower expectations for their academic success and potential, and tend to report them more often than their White counterparts as experiencing behavioral problems (Cornbleth & Korth, 1980). Consequently, African American students drop out of school in record numbers because of the differential attention, and due to their feelings of alienation.

Brown (1994) believes that desegregation has served to undermine the academic achievement of African American children in significant ways. Many African American neighborhood and community schools were closed, and African American children were bused to predominantly White neighborhoods.

Consequently, African American children lost important academic community anchors. The racial composition of schools that remained predominantly African American changed radically. Black teachers were fired and replaced with White teachers (Bankston & Caldas, 1996). At the onset of desegregation, 6,000 Black teachers were dismissed, and 25,584 were displaced (Jones, 1994). Some White teachers viewed teaching in these schools as a less desirable assignment. The least qualified and least experienced teachers were assigned to Black schools (Bruno & Doscher, 1981). Thus, as a result of desegregation, African American children lost academic role models.

There are researchers who counter and maintain that there is ample evidence to suggest that desegregation has had a positive impact on the academic achievement of African American children. As a consequence of desegregation, the reading achievement scores of African American children have improved in the last two decades, the dropout rates for African American students have decreased in the last three decades, and there have been advancements made in interracial social relationships and job opportunities (Schofiled, 1995). Furthermore, the achievement gap between African American students and White students has narrowed considerably due primarily to desegregation (Mahard, & Crain, 1983).

Forty-eight years after the *Brown v. Board* decision, as stated in the Insider's Voice, the resegregation of African American children in the public school system is on the rise and approaching the levels of 1970. Nationally, a third of African American children attend schools where the enrollment is 90–100% minority. The concern as raised by Dr. Orfield in the Insider's Voice is that these schools do not equip African American students with the academic skills they need to succeed. Unfortunately, African American parents expressed this same concern more than 40 years ago.

Social scientists have also voiced concerns about the plight of African American children in the public school system (Trent, 1997).

African American children comprise 50% of the enrollment in 9.7% of America's public elementary schools (U.S. Census Bureau, Statistical Abstracts of the United States, 2006). They are enrolled primarily in schools located in the urban areas of the United States and schools located in areas with high concentrations of poverty.

Based on indices of academic achievement, African American children have not fared well in the public school system. On critical measures of academic achievement, African American students consistently lag behind their White counterparts. Data in Figures 5.1–5.3 compare the reading, writing, and math achievement test scores of African American fourth graders and White fourth graders. The data in the tables suggest that the performance of fourth graders on reading, writing, and math tests has been steady, with few remarkable

changes in achievement for more than two decades. However, when the performance of African American children is compared to that of their White counterparts, the achievement gap is most observable in the reading achievement scores. This suggests that on the one hand, African American children are able to follow brief written directions, and engage in simple reading tasks. On the other hand, the pattern indicates that African American fourth grade children are not developing the reading skills necessary to master complex reading material.

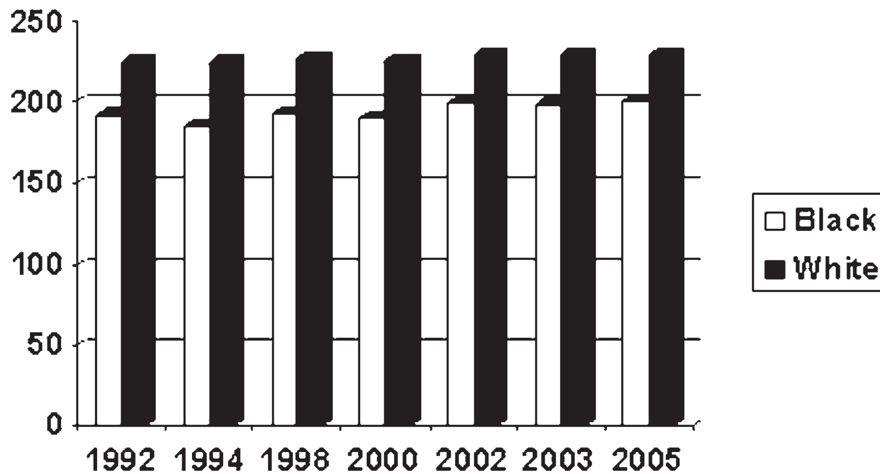


FIGURE 5.1 Fourth Grade Reading Proficiency Test Scores, 1992–2005
Source: National Center for Education Statistics, 2006.

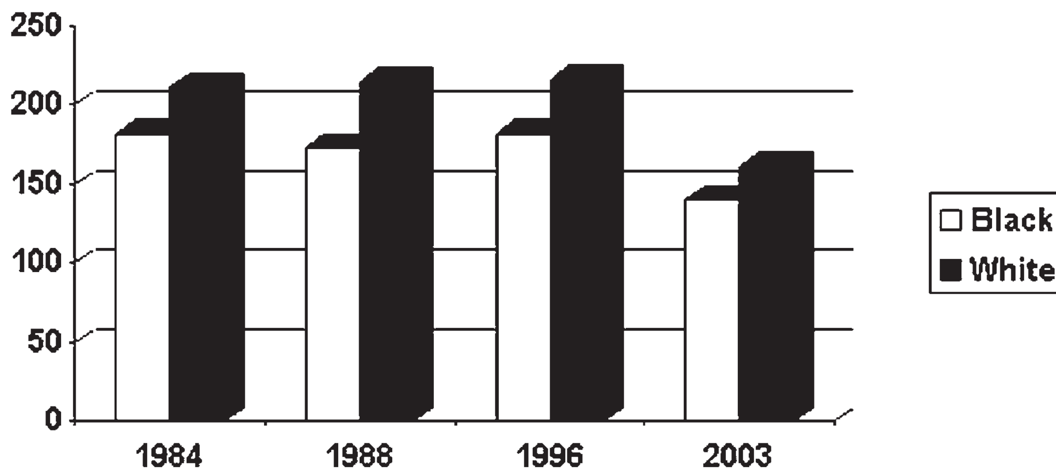


FIGURE 5.2 Fourth Grade Writing Proficiency Test Scores, 1984–2003
Source: U.S. Census Bureau, and Statistical Abstracts of the U.S., 2003.

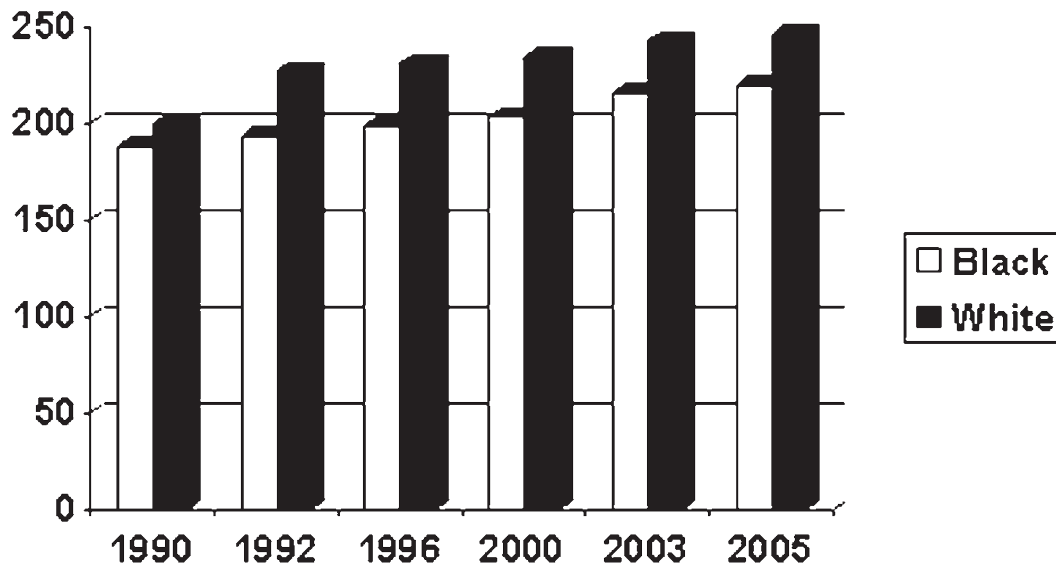


FIGURE 5.3 Fourth Grade Math Proficiency Test Scores, 1990–2005
Source: National Center for Education Statistics, 2006.

Over the past several decades, a myriad of theories have been proposed to account for the achievement gap between African American children and White children. These theories have ranged from genetic inferiority accounts (Hernstein & Murray, 1994), to environmental deprivation perspectives (Scarr & Weinberg, 1978), to socioeconomic status, to persistent economic hardship views (Duncan & Magnuson, 2005); parenting practices (Brooks-Gunn & Markman, 2005), the quality of early childhood education programs (Magnuson & Waldfogel, 2005) to cultural background (Boykin, 1986).

According to Irvine (1990), Garabaldi (1997), and Pollard (1989), the achievement gap is not a result of those factors, but due to an interaction of factors inherent in the structure of the public school system that predispose African American students for academic failure and leave them ill-prepared for college and gainful employment.

The factors inherent in the structure of the public school system include placement in special education classes, teacher attitude and expectations, peer influence, and parental involvement.

Placement in Special Education Classes. African American children are disproportionately placed in classes for the educable mentally retarded (EMR) based on their performance on intelligence tests and achievement measures.

In an analysis of 505 school districts in Alabama, Georgia, South Carolina, Mississippi, and Arkansas, over 80% of the students enrolled in educable mental retardation (EMR) classes were Black and the majority of these students were African American males. African American students comprise 16%

of the public school population, but 35% of the special education population (Harry & Anderson, 1994). These placements begin at an early age and for many African American students there are few opportunities to re-enter regular classes (Oakes, 1995).

Placement in special education classes affects students' academic performance in a variety of ways. First, the quality of teaching and teacher student interaction differs markedly from the quality of teaching and teacher student interaction found in regular classes. Oakes (1995) found that teachers of African American students in special education classes expect less of them. These expectations are often reflected in their teaching styles and interactions. During those interactions, teachers provided students with fewer opportunities to learn essential information and to build the academic skills that prepare them for high school completion and gainful employment. Second, students placed in EMR classes fail to make achievement gains. In fact, achievement test scores decrease from grades three through eight. Third, students' self-concept and peer relationships are damaged as a result of the stigma associated with placement in special education classes (Trent, 1997).

The placement of African American children in special education became a legal issue in the 1970s (Macmillian, Hendrick & Watkins, 1989). Two cases, *Diana v. Board of Education* (1970) and *Larry P. v. Wilson Riles* (1971), serve as the landmark cases, prohibiting the use of IQ tests to assign African American children to special education classes. In both of the cases, the litigants argued that standardized IQ tests used to assess African American children were culturally and racially biased; and placement in special education resulted in little remediation or efforts to improve their deficits. Consequently, these students failed to complete high school and were unable to secure employment as adults (Reschly, 1982).

The judge concurred with the plaintiffs and ruled that the method of evaluating and placing students was inappropriate in two ways: Standardized tests were discriminatory toward African American students; and the history of placing African American students in EMR classes pointed to unlawful segregated intent (Prasse & Reschly, 1986).

As a result of the court ruling, changes were implemented in both testing and placement policies, especially for African American children and other children of color. Guidelines for nondiscriminatory assessment were developed (see Table 5.1), and Public Law 94–142 was established to ensure due process and legal protection for African American children and other children of color (Gardner & Miranda, 2001).

Despite the public law, the legislation mandating changes in testing African American children, and the development of nondiscriminatory guidelines,

TABLE 5.1 Guidelines for Nondiscriminatory Assessment

1. A student must be assessed in their native language.	5. Every student identified as having a disability must be re-evaluated every 3 years.
2. Tests must evaluate what they were intended to evaluate.	6. An individual educational plan must be developed for each child.
3. Examiner must be appropriately trained to administer and interpret specific test results.	7. Parents must be involved in discussions of placement and assessment.
4. Placement decisions cannot be made on the basis of any single factor. A multidisciplinary team or group of educational practitioners must make the decision.	

Source: Wodrich, (1997). Children's Psychological Testing.

African American children still remain overrepresented in EMR classes (Gardner & Miranda, 2001).

Social scientists speculate that this practice continues because teacher training programs fail to adequately expose teachers to cultural issues and how those issues impact test performance of African American children; schools are not monitored for their compliance to the federal law; and are not required to demonstrate improvement in tests scores of children placed in EMR classes. (Nelson, 1995)

Teacher Attitudes, Expectations and Teaching Styles. The teacher expectancy theory holds that teachers communicate both subtly and overtly their attitudes and expectations about their students' achievement capabilities. In response, students perform according to the teacher's attitudes and expectations (Rosenthal & Jacobson, 1982). In the specific case of African American children, researchers have observed that very often teacher attitudes and expectations for success are lower for African American students than for White students (Seyfried, 1998).

Beane (1985) found that even when academic performance is similar, teachers view African American students as low achievers and majority students as high achievers. They are critical of their academic work and pessimistic about their prognosis for academic success; they often judge Black students as the least studious and least prepared, and the teachers describe the Black students as talkative, lazy, fun-loving, high strung, and rebellious. In one detailed observation of student-teacher classroom interaction, White students received more praise and encouragement for their classroom performances regardless of the teacher's race than did African American students (Baker, 1999).

Rong (1997) proposes that these teacher attitudes and expectations are caused in part by cultural incongruence: The majority of the teachers are White, female, middle class graduates of teacher training programs. The programs provide little guidance on working with children of color. Therefore, the teachers may have pre-set and sometimes unfavorable notions about the intellectual and academic capabilities of African American children.

In addition to teacher attitudes and expectations, the teaching techniques used in urban school settings fail to prepare and equip African American students with important academic skills and critical learning skills. Carta (1991) found that in a typical day in an inner-city classroom, students are exposed to more audiovisual materials and teacher-directed class discussions than one-on-one teacher interaction and independent seat work. The former requires less active responding from the students, encourages passive attention, and results in lower levels of achievement (Carta, 1991); or what Greenwood, Hart, Walker, & Rishley, (1994) refer to as "developmental retardation." As a consequence of this type of instruction, which fails to challenge and actively engage African American students with the material, students lag behind their peers in suburban schools in their mastery of basic academic skills; and this is reflected in their performance on state and national achievement tests (see Box 5.2).

In terms of specific academic subjects, Strutchens and Silver (2000) found that in the area of math instruction, teachers tend to emphasize reasoning skills in their instruction to White students, whereas teachers tend to use drill-based instruction with their African American students. In terms of assessment, Lubienski (2002) found that African American children are more likely than their White counterparts to receive multiple choice exams, and exams that require fewer computational and reasoning skills.

BOX 5.2

Is there an African American Learning Style?

Several social scientists have encouraged educators to tailor their teaching style to the learning and cognitive styles of African American children (Hurley, Boykin & Allen, 2005; Watkins 2002; Willis, 1992). These scholars maintain that the teaching and instructional style used in most elementary schools is an analytical type of style. This type of style involves the use of rules, encourages memory for specific facts, emphasizes the use of logic, and utilizes deductive reasoning. According to Hilliard, this is in contrast to the cognitive style that African American children use to process information. Their style is a relational cognitive style that emphasizes the use of freedom of exploration, memory for the essence of material, and the use of inductive reasoning.

The information presented in the preceding section discusses the major factors that are believed to influence albeit negatively, the academic performance of African American children in the public school system. Other factors such as academic self-confidence, peer influence, and alienation of African American parents from the school system are also linked as well.

Academic Self-Concept and Peer Influence. Some scholars argue that the public school system has created a sense of learned helplessness or a cycle of frustration within African American children and as a result their academic performance is adversely impacted (Graham, 1994). According to Claude Steele (1995), as a consequence of repeated exposure to indifferent and negative treatment from teachers, African American children internalize those experiences, and construct a "mental model." This mental model is easily retrievable even when the stimulus is absent. Steele refers to this as stereotype threat. Any situation can trigger the activation of the mental model, and those experiences become so salient and vivid that the children foreclose on their academic abilities and their academic performance is hampered.

Alternately, Fordham and Ogbu (1986) argue that African American children seek out negative experiences, which affirm their sense of low self esteem, in order to protect their identity or buffer their self-esteem from the indifferent and negative treatment received in school. This is acted out in their resistance or opposition to teachers, or to the authority structure of the school. The peer culture, rather than the school culture, becomes the respected authority figure in the school environment. Peers then, play a profound role in influencing each other's academic achievement. This peer culture provides opportunities, especially for African American boys, to demonstrate competence and to maintain a sense of self-respect (Polite & Davis, 1999).

Alienation of African American Parents From the Educational System. Researchers have long acknowledged that parental support and involvement in the academic lives of their children is a key variable in ensuring the academic success of children (Tucker, Harris, Brady, & Herman, 1996). However, low-income African American parents do not participate at the same level as do middle class parents in the academic lives of their children (Halle, Costes & Mahonney, 1997). Such factors as their single parenthood, their socioeconomic status, and their low educational attainment level have been identified as contributing to their low participation rates (Zionts, Zionts, Harrison, & Bellinger, 2003). Teachers often describe low-income African American parents as uninterested, inaccessible, and difficult to communicate with (Trotman, 2001). Low-income African American parents on the other hand, report feeling unwelcome, alienated, dismissed, and unfairly treated by both teachers and administrators in the public school system. Therefore, they limit their contact with teachers and administrators.

Trotman (2001) offers the following ten suggestions for increasing the involvement of low-income African American parents (Box 5.3).

BOX 5.3

Increasing African American Parental Involvement in Schools

1. Urge parents to remain or become active in their children's educational process.
2. Make sure that each child is properly educated and attends school regularly.
3. Develop a case history of the family in an effort to determine what is hindering their involvement.
4. Establish a rapport with parents.
5. Provide parents with authority.
6. Follow the lead of chapter 1 programs. Implement programs which assist parents in developing their own academic skills.
7. Ask parents about their interest in school.
8. Ask parents who attend meetings to spread the word to other parents.
9. Use parents as teaching partners.
10. Do not judge or criticize parents.

SECTION TWO: SCHOOLS THAT WORK FOR AFRICAN AMERICAN CHILDREN

There are public and private schools located across the United States that are effective in facilitating the academic success of African American children. These schools provide African American children with a solid educational foundation that prepares them for college and later employment opportunities.

The next section of the chapter focuses on discussing the characteristics of both public and private schools that work for African American children.

Public School Models

The concern with the failure of public schools to effectively educate African American children forced scholars to critically examine the structure of the public school system, identify those aspects that were in need of modification, and develop and implement programs or models that were sensitive to African American cultural and historical issues.

These schools follow either James Comer's School Development Program Model, or Ron Edmonds Effective School Model. Examples of these schools were highlighted in the 1988 special issue of the *Journal of Negro Education*. Each school is located in an urban area, where the majority of the families are low income, and the majority of the children are from single-parent family homes. Each of the schools has received both national and local recognition for significantly improving the students' achievement test scores, increasing school attendance, and decreasing disciplinary problems.

Dr. James Comer conceived the idea of the School Development Program (SDP), in 1968, with the conviction that schools located in low-income areas were capable of providing African American students with a quality and a solid education. He believed that public schools could improve academic achievement outcomes for African American children if collaborative relationships were established between administrators, teachers and parents; he also believed that administrators, teachers, and parents, rather than district school boards, should assume the leadership role and determine the structure of key aspects of the school. The core features of the SDP are presented below.

Governance and Management Team. This team is composed of the principal, teachers from each grade level, parents, and members of the mental health team. This team is responsible for implementing academic plans and evaluating curricula, staff development, student achievement, and the general climate of the school. Unlike typical urban public schools, which are under the auspices of school boards, or the principals, the governance and management team, assumes total control over the functioning of the school.

Mental Health Team. The mental health team, according to Comer, is a crucial and important element of the school. In typical urban public schools, there is usually one school psychologist (with a very heavy cases load) assigned to several schools, shouldering the responsibility for working with a number of teachers and students from many school districts. This person is also responsible for assessing and meeting the mental health needs of the students.

In the SDP, this becomes the responsibility of a team of individuals called the mental health team. This team is composed of social workers, psychologists, and teachers who provide counseling and assessment for students, consult with teachers, and offer outreach to the children and their families. In addition, the team is in charge of developing and implementing alternative methods for dealing with behavior problems.

Parent Participation. Parents assume a variety of roles in the SDP model, ranging from being classroom aides and hall monitors to library assistants. Unlike in the typical urban public school setting, parents' participation is actively sought and rewarded.

Staff Development and Training. In the usual urban school setting, the focus of staff development and training is decided by the school administrators or principals. In the SDP model, teachers select the topics as well as the consultants.

How do children who attend schools which employ the SDP model perform? According to Haynes, Comer and Hamilton-Lee (1988), there have been observed changes in both academic achievement and the school climate. Over a four-year period, schools employing the SDP model have experienced significant increases in reading and math scores, exceeding both district and state level performances. Furthermore, these schools have observed a decrease in suspensions and behavioral problems. However, a more recent comprehensive independent evaluation of schools employing the Comer SDP model (Cook, Murphy & Hunt, 2000) found that over a 4-year period, although initial improvements were observed in academic performance, behavior problems, and truancy, these gains faded by the end of a 4-year period.

The late Dr. Ronald Edmonds (1982), who like Dr. Comer held that the urban public school system could be reformed to improve the academic achievement of African American children, developed the Effective Schools Model (ESM). However, unlike the SDP, which provides guidance on implementing structural changes within the school, the ESM is a prescriptive for attitude and behavioral change for principals and teachers who work in low-income urban public school environments. The ESM consists of the following prescriptives.

Principals. The ESM encourages principals to assume the role of the instructional leader of the school. They model for teachers an attitude of genuine concern for the academic performance of all children in the school, and an acceptance of the "cultural background" of the children. In addition to their role as instructional leaders, according to the ESM, principals should have an open door policy for parents, and an egalitarian approach to decision making in the school.

Pedagological Attitudes. The teachers and the principal must embrace similar goals related to students' academic achievement and share similar goals on strategies, techniques, and methods to achieve the students' school success.

Provide a Safe and Community-Like Climate for Learning. The school must visually reflect the attitudes of success embraced by principals and teachers. Student work should be displayed; student academic honors should be acknowledged, and the school environment must be safe and in excellent physical condition.

Professional Staff. Teachers should hold similar expectations for the academic capabilities of all of their students and adopt flexible assessment and

instructional techniques. According to the ESM, teachers are "driven by pupil performance," and they should adjust their teaching techniques to maximize student mastery and performance.

Flexible Assessment and Instruction. According to the ESM, assessment should be used for diagnostic and remedial purposes rather than placement purposes. The Harford Heights model uses "continuous student assessment" which involves diagnostic tests, summative tests, and proficiency tests, as well as standardized tests.

Examples of the schools that use the ESM are presented in Box 5.4.

Reform movements such as the ones described above have not proved successful in approving academic performance, especially of African American males. That is, schools that employ models such as the SDP or the ESM have not produced significant and lasting gains in the education of African American students (Pollard & Ajirotutu, 2000). Other efforts have focused on creating schools within the public school system designed specifically for African American students. These schools are called immersion schools. Box 5.5 describes an Immersion School.

BOX 5.4

Examples of Schools Which Use the Effective School Model

1. Stowe Middle School is located in a midwestern urban environment with 80% African American enrollment. Achievement test score performance indicates that over a 7-year period 95% of the students were passing all sections of proficiency tests (Young, 1988).
2. Harford Heights is located in an eastern urban environment with 95% African American enrollment. There were overall increases in achievement scores in a 3-year period, as well as an increase in school attendance (Nicholsonne, 1988).
3. Lee Elementary School is located in a midwestern urban environment, with 98% African American enrollment. Test scores have improved an average of 64% since the implementation of the ESM (Hughes, 1988).

Independent Black Schools (IBS)

Independent Black Schools have served a critical role in educating African American children for more than two centuries (Lomotey, 1992). The first

BOX 5.5

What Is an Immersion School and Does It Work?

Immersion schools were developed in the early 1990s with the aim of improving the academic achievement of African American children, especially African American males. The pedagogy is primarily African-centered education, derived from an Afrocentric worldview, that focuses on the ways in which African culture and people of African ancestry have contributed to the world (Leake & Leake, 1992).

In Milwaukee Wisconsin, 5,700 of the African American males enrolled in the city's high schools were performing below average, and nearly 50% of them were dropping out of school. To address the problem, Milwaukee created two schools focusing specifically on the needs of African American males. One school targeted elementary school males and the other school targeted high school students. The schools were designed to meet the academic and social needs of African American males; and assist them in developing social competence, communication skills, as well as problem solving and critical thinking skills.

A mentoring program is a core part of the immersion schools' concept and teachers are required to make 18 home visits per semester.

What does an immersion school look like? The structure of the curricula differs significantly from the typical public school. The focus of the curricula is on the contribution of Africans and African Americans to history. Lessons are designed to highlight African culture and history. Such topics as social studies, language arts, math, and home economics would be introduced in the context of a traditional African marketplace. In contrast to the typical public school, there is more of an emphasis on cooperative learning in immersion schools. Finally, the physical environment of the immersion schools reflects an Afrocentric theme (e.g., maps of Africa displayed throughout the school).

How effective are immersion schools? Pollard & Ajirotutu (2000) evaluated the effectiveness of the Milwaukee African American immersion schools, measuring changes in teacher attitudes as well as changes in student performance, both academic and behavioral. They found that at the end of a 5-year period, the students' achievement performance had increased, where 92% of the third graders were performing at or above the state average on math and reading measures. In addition student suspensions and behavioral problems decreased as well. Teacher attitudes had become more favorable about their work environment, although some attrition had occurred during that time period.

Independent Black School (IBS) was founded by Prince Hall in 1798 as a result of his unsuccessful petitions to the city of Boston to establish a separate tax-supported school for Black children (Ratteray & Shujaa, 1987). The civil rights era produced the second wave of IBS. The Freedom Schools of the South represent an example of this effort. These schools were designed to provide African American children during 6 weeks of the summer with academic curricula that focused on remediation and African American history. Since then IBS have been formed to provide African American children with alternatives to the public school system.

The Independent Black Schools are under the auspices of the Council of Independent Black Institutions (CIBI) founded in 1972. CIBI provides teacher training and conducts annual science competitions for participating schools. There are currently 40 IBSs located throughout the United States. The enrollment ranges from a low of 50 to a high of 200 students going from preschool up to twelth grade, however the highest concentration is at the elementary level. Each IBS consists of a board of directors responsible for establishing school policy; a parent-teacher organization; and a director, in charge of the administration of the school (Ratteray & Shujaa, 1987). The schools are supported primarily by student tuition.

African American children who attend IBSs come from families with diverse socioeconomic status backgrounds and educational backgrounds. IBSs have become educational choices for some African American parents, who express their concerns about the capability of the public school system to effectively educate their children (Ratteray & Shujaa, 1987).

The academic structure of an IBS is similar to that of the typical public school. However, similar to the immersion school concept, the goal of the IBS is to link African cultural knowledge with traditional subject matter. Such topics as math and science are discussed in terms of their historical and cultural significance. A lesson on the counting system might initially focus on the chronological and historical development of counting systems in Africa. Students are then taught to count in both ancient Egyptian and Yoruba systems (Akoto, 1992).

Integrated within curriculum is an emphasis on the seven principles of Ngusabo (Karenga, 1982). These values are introduced to the students in a variety of ways, including establishing dress codes, writing stories, developing cooperative learning experiences, and celebrating holidays (e.g. Kwanzaa). Finally, the role of teachers in an IBS is perceived to be critical for the students' success. Teachers serve as surrogate parents and role models.

How do children who attend IBSs perform on measures of achievement? Ratteray and Shujaa (1987) found that students attending IBSs performed at or above the national norm on such achievement measures as the Comprehensive Test of Basic Skills, the California Achievement Test, the Iowa Test of Basic Skills, the Metropolitan

Achievement Tests, and the Stanford Achievement Test. Sixty-four percent of the children scored above the norm on reading and 50% of the children scored above the norm on math. Children attending IBSs also have a higher sense of self-worth; they experience positive peer pressure, and are more likely to attend college than students not attending an IBS (Ratteray & Shujaa, 1987).

Essentially, the act serves as a blueprint for change, as well as emphasizes the use of incentives and sanctions to produce improvement in achievement test scores.

Has the achievement gap closed since the implementation of NCLB (see Box 5.6)? The answer to this question depends on the source. In April 2006, the federal government issued the following brief report documenting the improvement of African American children improvement on various achievement measures.

- Reading scores for African American fourth graders have increased.
- The achievement gap between African American and White fourth graders is at an all time low in reading and math.
- Studies by the Council of the Great Schools released in March 2006 showed urban students to be improving in reading and math.

BOX 5.6

No Child Left Behind and African American Children

In 2002 President George W. Bush signed into law Public Law 107–110, which is known as the No Child Left Behind Act (NCLB). The law is a reauthorization of the Elementary and Secondary Act of 1965. The general thrust of the law is "to close the achievement gap with accountability, flexibility, and choice so that no child is left behind." The NCLB law is a 1425-page document that provides direction and guidance to school administrators, and teachers on four basic reform principles.

1. Strong accountability for results
2. Increased flexibility for local control
3. Expand options for parents
4. Emphasize teaching methods proven to work

A comprehensive study by Sunderman et al. (2004) sheds light on teacher perception and reaction to NCLB. According to the findings, while teachers are generally supportive of the mission to improve the academic achievement of

children who are attending low-performing schools, they are uncertain about the capability of the law. The law requires there to be a public identification of underperforming schools and a subsequent implementation of sanctions. Students are also allowed to use school vouchers and options. These three policies are meant to improve outcomes for children attending low-performing schools. Many teachers argue that the consequences of these policies will only serve to undermine teacher confidence, encourage teacher flight from low-performing schools, and encourage parents to remove their children from low-performing schools. Furthermore, the law discourages teaching other subjects and encourages a form of teaching to the tests.

The general dissatisfaction with the law is echoed by Mathis (2005) in his article entitled "Bridging the Achievement Gap: A Bridge Too Far?" He raises the following concerns about the effectiveness of NCLB in producing immediate and long-term improvements in the achievement test performance of African American children:

- To effectively and completely close the achievement gap, the underlying problems in society must be confronted.
- Second, poverty, rather than educational reform, is a larger influence on the variance of improving test scores. Schools with high concentrations of poor and minority students will fail to make adequate yearly progress.
- Third, even successful schools fluctuate in achievement gains.

SECTION THREE: AFRICAN AMERICAN CHILDREN AND EARLY INTERVENTION PROGRAMS

A chapter on education is not complete without a discussion of African American children and early intervention programs.

The momentum established by the *Brown v. Board of Education* decision and the 1964 Civil Rights Act laid the groundwork for the types of educational experiences that African American children would encounter for the next four decades. One outcome of this was the development of compensatory education programs or early intervention programs for poor children. These programs were designed with the goals of enhancing the educational readiness of poor children, providing poor children and their families with access to health care and other social support services. The programs that African American children participate in, or have participated in, are discussed below.

According to data released by the U.S. Census Bureau (2006) the percentage of African American children enrolled in preprimary education (67%) is

slightly higher than the percentage of White children (65%). These programs are primarily federal and state funded early intervention programs, although some African American preschool children attend privately operated preschool programs (Magnuson & Waldfogel, 2005, Wasik et al., 2000).

The programs are frequently identified in the educational and social science literature as effective early intervention programs, and at some level they have demonstrated positive outcomes for African American preschool children and serve as models for other state and local early intervention education programs.

Head Start

Head Start began in the summer of 1965 as a part of President Lyndon B. Johnson's war on poverty. Initially designed as a summer enrichment program for poor children, in 1972 Head Start expanded to a 9-month program designed to offer a variety of services to poor children and their families. Today there are over 1,500 Head Start programs located in rural and urban areas across the United States. Serving approximately 700,000 children, 40% of the children enrolled in Head Start are African American between the ages of 2 and 5 (Digest of Educational Statistics, 2003).

Head Start provides comprehensive services to the children and their families ranging from providing preschool educational services and health services to job training for caregivers. The Head Start curricula involve exposing the children to a variety of academic related activities including learning words, colors and numbers. Health care provides the children with access to vision and hearing screening tests, and immunizations and dental exams. Children and caregivers also have access to psychological and behavioral services. Parents are provided with information on job training, the opportunity to complete their education, and the opportunity to attend parenting classes. As part of this component, parents also have a voice in the administrative decisions of Head Start. Finally Head Start provides outreach and referral services for families (Zielgler & Muenchow, 1992).

How effective is this early intervention program for African American children? Answering this question is difficult for various reasons. One reason is that data are rarely separated by race, so it is difficult to tease apart the impact of this program on improving the cognitive and intellectual performance of African American children. Another reason is that the programs have varied from state to state, so tabulating the comprehensive impact is difficult to document. Third, the methodology used in collecting the data has varied as well: Studies have differed significantly in terms of type of IQ outcome measure used, subject demographics, and sample size.

Nevertheless, two decades of research on Head Start indicates that there are two patterns of how Head Start has affected the African American children who have participated in the program. The first pattern shows that in comparison to a control group, African American children who attend Head Start generally score higher on standardized language performance measures (i.e., they have higher Peabody Picture Vocabulary [PPVT] scores) and score higher on other measures of achievement (Barnett, 1993). The second pattern shows that these differences seem to fade by third grade and completely disappear by middle school and high school (Curie & Thomas, 2002; Westinghouse Learning Corporation, 1969). However, when researchers used other indices such as school attendance, grade retention, graduation rates, premature parenting, and placement in special education classes, they found that in the longterm, participants in Head Start are less likely to be truant, less likely to be placed in remedial education classes, more likely to graduate from high school, more likely to have higher achievement motivation scores and goals (Slaughter-Defoe & Rubin, 2001), and lastly, less likely to become teen parents in comparison to those who do not participate in Head Start (Lee, et al. 1990).

Curie and Thomas (2000) offer some insight into why the gains fade for African American children particularly in the areas of IQ and academic achievement. They argue that this is because African American children in comparison to their White counterparts are more likely to attend schools that are of inferior quality.

Head Start has had a significant impact on improving the lives of parents as well. Many of the parents have completed their education, participated in job training programs to secure employment, and attended college (Bruckman & Blanton, 2003).

High/Scope Perry Preschool Project

The High/Scope Perry Preschool program was started in 1962 by the High/Scope Educational Research Foundation in Ypsilanti, Michigan, and is one of the best-known longitudinal studies examining the influence of early intervention on the cognitive and social development of low-income African American children (Barnett, 1993). One hundred twenty-three African American children between the ages of 3 and 4 participated in the project. Fifty-eight were assigned to the preschool program, and 65 were assigned to the no-preschool control group. The groups were closely matched on such demographic characteristics as maternal education level, income level, and on cognitive and intellectual performance measures. Those preschoolers participating in the two-year intervention program attended 2½ hour

morning classes and were visited in their homes weekly by their teachers for 90 minutes. IQ demographic data and teacher ratings were collected at ages 11, 14, 15, 19, and 28. The findings revealed that participants in the preschool intervention program were more successful academically (e.g., fewer grade retentions, higher academic achievement scores, and better high school graduation rates) as well as socially (e.g. fewer arrests and fewer out of wedlock births) than those who did not participate in the intervention program.

Why has this program been so successful? According to the project coordinators, as a result of their participation in the program, the children developed school-readiness skills, which prepared them for successful interactions with teachers and helped them to develop positive attitudes about school. Seitz (1990) believes that the home visitation component of the program was an essential ingredient for the academic and social success of the participants. She speculates that parents gained experience in developing positive and comfortable relationships with teachers and they continued this pattern of interaction with teachers throughout the grade school years. They modeled positive behaviors for their children and indirectly influenced their attitudes about school and their academic success.

The program is no longer in operation, but is often cited in the literature and by politicians as an exemplary intervention program for poor African American children.

The Abecedarian Project

The Abecedarian project began in 1972 as an experimental intervention program. The overall goal was to determine the effectiveness of early intervention on later outcomes for African American children. The basic methodology involved assigning 111 infants to an experimental group or control group. The experimental group received 5 years of educational intervention that involved year-round full-day educational childcare, or preschool, along with nutritional supplements, and social support services for the families. The control group received everything but the educational intervention. The results indicated that at age 15, the experimental group in comparison to the control group performed better academically, and required fewer social or remedial services (Campbell & Ramey, 1994).

What conclusions can be drawn about African American children and early intervention programs? Do early intervention programs prepare African American children to succeed in elementary school? Some scholars would argue no, because there is a great deal of discontinuity between the structure of these early intervention programs and the structure of elementary school.

Even with the implementation of Project Follow Through (an elementary form of Head Start), the elementary school experiences can undo the advantages of a year of Head Start and other early intervention programs (Lee et al., 1990).

Future research about Head Start should attempt to isolate the components of the program that most effectively impact achievement. Given the number of African American children who enroll in Head Start, Head Start can serve as a natural laboratory for developing ways to improve education for African American children overall.

PERSPECTIVES ON EDUCATION AND AFRICAN AMERICAN CHILDREN

According to John Jacobs (1989), "there is a growing number of African American youth who face a perilous economic future because they are not adequately prepared to participate in an economy that is undergoing fundamental structural change." Jacobs, then president of the Urban League, made this statement as part of his commentary on the "state of education and African American youth." Eighteen years later, the academic achievement of African American children remains a pressing concern for educators, social scientists, and politicians.

For the past few decades, a plethora of intervention programs, policies, and reform movements have been designed all with the goals of narrowing the achievement gap between African American children and their counterparts from other racial groups. There has also been an exponential increase in the number of books, pamphlets, and articles written on the issue. Despite this attention, the achievement gap persists. Perhaps, it is time to explore other questions about academic achievement and African American children, and focus on identifying the teaching techniques and strategies that facilitate achievement. Furthermore, research should begin to examine effective approaches to engaging poor and disenfranchised African American parents into the academic lives of their children.

The reform movements have had a questionable impact on the academic achievement of African American students (Pollard & Ajirotutu, 2000).

As Theresa Perry (2003) states, "a problem as complex as eliminating the achievement gap requires effort and ideas from many people." The issue of eliminating the achievement gap as well as the issue of resegregation of American public schools will dominate the focus of discourse, politics and research in the 21st century.

CHAPTER SUMMARY

The chapter begins with a discussion of school desegregation. The landmark case *Brown v. Board of Education* changed the educational process for all children in the United States. There is a growing trend toward resegregation of American public schools.

The chapter continues with a discussion of the plight of African American children in the public school system. It is evident from the available achievement data that African American children continue to lag behind their counterparts from other ethnic groups by an average of 30 points on critical measures of academic achievement. School factors (e.g., teacher perception), self-concept, peer influence, and parental involvement are identified in the chapter as causal factors.

Reform movements in the 1970s and the 1980s produced schools with the primary agenda of educating African American children. Those movements have offered suggestions on restructuring schools and offer prescriptives for attitude and behavioral change for teacher and administrators.

Independent Black Schools (IBS) are alternatives to the public school system for many African American children. In addition to the rigorous education, IBSs provide African American children with information about their cultural heritage. According to recent achievement data, African American children who attend IBSs score at or above the national average on achievement measures.

The chapter concludes with a discussion of African American children and early intervention programs. African American children are more likely than their White counterparts to participate in early intervention programs. However, due to the variability in the academic structure and the focus of those programs, achievement gains are negligible or fade by first grade.

ADDITIONAL READINGS

Desegregation

Beals, M. (1994). *Warriors don't cry: A searing memoir of the battle to integrate Little Rock's Central High School*. New York: Pocket Books

Irons, P. (1994). *Jim Crow's children: The broken promise of the Brown decision*. New York: Penguin Press.

Education

Ladson-Billings, G. (1994). *Successful teachers of African American children*. San Francisco: Jossey-Bass.