CHALLENGE

A Journal of Research on Black Men

Inaugural Issue

July, 1990 • Volume 1, No. 1

Morehouse College • Atlanta, Georgia

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Challenge is the official organ of the Morehouse Research Institute *(MRI)*, an interdisciplinary research institute whose principal objectives are to encourage relevant scholarship and to build a viable information exchange network so that policies and programs, particularly those germane to the status of African American men and boys, will be firmly grounded in research. Activities *MRI* will initiate include the Scholars Program, the National Data Base, and the Information Exchange Network and Clearinghouse.

Typically, future issues of *Challenge* will contain proceedings of the focus groups, conferences and symposia sponsored by *MRI* as well as invited occasional papers and reports on topical concerns such as explorations of priorities for future research and policy analysis and the identification of policy implications for program development of agendas for change.

Additional copies of this inaugural issue are available at $6.00 each from the Morehouse Research Institute, Morehouse College, 830 Westview Drive, S.W., Atlanta, GA 30314.

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Foreword

On March 15 and 16, 1990, in the Afro-American Hall of Fame, Morehouse College convened the *First National Meeting on the Status of Black Men in America* to inaugurate the Morehouse Research Institute *(MRI)*. A diverse group of over 50 researchers, activists, educators, and policy makers came from across the nation, representing a broad spectrum of political, social, and ideological predispositions. On those two days, however, there was a common agenda. It was prompted by the dismal reports on the status of African American men and boys: declining college enrollments; increasing joblessness, even among high school graduates; disproportionate numbers of black male perpetrators and vicitims of interpersonal violence; excess morbidity and mortality; and escalating rates of substance abuse, homicide, and suicide.

The papers in this volume were presented at the inaugural meeting. The primary aim of these works is to inform, to raise awareness, and to increase sensitivity to the need for multidimensional approaches in formulating agendas and developing strategies to address what has been labeled the black male crisis, but is more appropriately identified as the *American* crisis.

It is particularly apropos that this initiative be taken at Morehouse College. Not only is Morehouse the only historically black college for men; but it was here, almost a century ago, that the great social scientist and activist W.E.B. DuBois began his studies of African American life. The purpose of DuBois' studies was to contribute to the formation of agendas for social reform.

The inaugural meeting of the Morehouse Research Institute was in the tradition of DuBois, as the vanguard of scholars and activists answered the call on behalf of their community and their nation. The papers in this volume are also in the tradition of DuBois as their work is centered in systematic analysis of the issues toward the end of informing policy formulation and program development. Future *MRI* meetings in 1990 and 1991 will focus on education and economic issues and family life. These meetings are made possible by funding from the Ford Foundation and the Rockefeller Foundation.

I Rousseau Mukenge
Project Director

Samuel L. Myers, Jr. is an economist specializing in the analysis of the impact of social policies on the poor. He has pioneered in the use of applied econometric techniques to examine racial disparities in the criminal justice system, to detect illegal discrimination in consumer credit market, to assess the impact of welfare on family stability, and to evaluate the effectiveness of government transfers in reducing poverty. Past president of the National Economics Association and member of the editorial boards of the review of *Black Political Economy, Social Science Quarterly,* and *Evaluation Review,* Dr. Myers is currently professor of economics and director of the Afro-American Studies Program at the University of Maryland at College Park.

David R. Williams is a sociologist whose major research and teaching specialties include social factors and health, intergroup attitudes, and survey research methods. Having earned masters degrees in both religion and public health and a doctorate in sociology, Dr. Williams applies this unique combination of skills and insights to the analysis of socioeconomic, psychological, and political factors in physical and mental health, particularly as they concern black Americans. His work is included in such publications as *Social Support and Health, An Introduction to Health Promotion Research,* and *The Health of Black Americans: Social Causes and Consequences.* Dr. Williams is professor of sociology and epidemiology and public health at Yale University.

Ruth E. Dennis is a sociologist whose research on suicide, homicide, and other manifestations of interpersonal violence has led her to make further inquiries into the precursors of violence, especially among black males. While an associate professor and director of research in the Department of Psychiatry at the Meharry Medical College, she conducted interviews of black male victims in an emergency room setting for her work on assaultive violence and homicide. Her publications include "Suicide Ideation in Black Male Homicide Victims" to be published in *Suicide and Life Threatening Behavior,"* "The Role of Alcohol in Black Male Aggression, and "Homicide in the Black Population in the South." She is presently professor of sociology at Austin Peay State University in Tennessee.

Drugs and Market Structure:
Is There Really a Drug Crisis in the Black Community?

Samuel L. Myers, Jr.
University of Maryland at College Park

Introduction

What was the number one public policy problem facing black communities in the late 1980s? Many human service sector professionals, who deal with the social cancers that seem to infect the black community in ways that defy solutions, will contend the answer is: drugs. Many in the law enforcement and corrections sector, who view the enormous problems associated with the dramatic explosion of prison populations during the 1980s, will say: drugs. And, for anyone whose version of world events comes from reading the morning Washington Post, the response will almost always be the same: drugs. The resounding theme of hundreds of editorials, news-specials, political speeches and even foot-stomping, bible-slapping sermons is the drug crisis in the black community.

Drugs seem to be the black killer of the 1990s. Drug policy, especially a national drug policy that until recently has focused on supply-side strategies, is viewed by many blacks as a policy aimed at destroying black youth. Drugs are a killer. Many blacks privately contend, however, that a bigger killer may be our misguided drug policies.

This contention, especially as uttered in private, is an expression of more alarming concern. Many blacks believe that national drug policies are not just misguided, but intentionally directed to achieve a horrible result: the elimination of a superfluous pool of already marginalized segments of the black population. Some have argued that drugs and drug policies in the United States are the moral equivalent of genocide.

This paper considers the issue of the drug crisis within a broader context of public policy-making and the black community. It offers evidence that challenges the conventional notion that drug use is on the rise and that black communities are being wiped out by the proliferation of cocaine and crack markets that are thriving in those communities' midst. The contradictory statistical indicators pose critical challenges for various public policy postures regarding drug markets. Simple partial equilibrium models demonstrate this contradiction. Within these models, however, it is possible to reconcile the conflicting evidence that: 1) overall drug use is declining; and, 2) drug addiction is on the rise among blacks.

Historical Backdrop

It is useful when considering the problem of drugs in the black community to examine related past instances of blacks in America becoming the victims of both misguided and intentional public policies that have deleterious impacts on the social and economic status of minority communities. There is a long history of a direct relationship between public policy formation in America and the status of blacks. While the words "slavery" and Negro or African never appear in the Bill of Rights or original articles of the U.S. Constitution, every strand of evidence points to the fact that public policy makers struggled from the start of this nation to deal with two groups that had at best an ambiguous legal standing: blacks and Indians. When one considers how public policy affects blacks from a historical perspective, one is struck by the fact that blacks have almost always been the subject of distinct public policy making. The state sanctioned efforts to enslave them; the judicial system upheld efforts to enfranchise them; legislative efforts were made to disenfranchise them; local efforts were made to isolate and control them; federal and congressional efforts were made to restore civil rights to them; and more recently judicial efforts were made to curb those earlier hard won rights that were designed with the intent to economically empower them; all of these efforts are parts of an ongoing interplay between the black community and public policy formation.

The most recent shift, during the Reagan Administration, toward retrenchment of Civil Rights serves as an important reminder that the relationship between blacks and public policy-making is dynamic, with many defeats and a few victories.

One valiant victory was the Civil Rights Act of 1964, which outlawed employment discrimination. It was the capstone of a series of efforts designed to open the doors of political and economic opportunity for blacks. Gunnar Myrdal argued in *An American Dilemma* that the major roadblock to the economic advancement of blacks was their lack of political empowerment. The main legacy of the Civil Rights Movement is a legacy of black political empowerment. By securing such basic civil rights as voting, unsegregated housing and nondiscriminatory treatment in employment, the black population was poised to assert its influence on public policies that would not only affect them, but the rest of the nation as well. No one would deny that one of the direct consequences of the civil rights movement was the political empowerment and enfranchisement of black people in America. And, with the civil rights victories of the 1960s came rising expectations for continued social and economic improvements for all blacks.

Yet, have those expectations been met? Many of the social and economic problems confronting minority communities today are as severe now as they were twenty-five years ago. Civil rights brought the dismantling of century-old laws and outdated, racist practices, but having legally sanctioned civil rights did not eliminate racial inequality. While some individual blacks saw their earnings increase dramatically, the incomes of the vast majority of black families continued to lag behind those of whites. Poverty rates were as high among black families in 1989 as they were in the 1960s. Crime seems as vicious and destructive now as it seemed when the Kerner Commission issued its report on black community problems after the riots of 1960s. Prisons, which have almost always been disproportionately black, are blacker now than ever. Welfare dependency, drug addiction, joblessness, all these problems still seem unresolved decades after national attention was directed toward what some have come to call the "black problem." In other words, black political power has not assured black economic power. This reality has not been lost on the black masses, nor on white conservatives.

An extremely disturbing current in public policy debates of the past decade is the tendency to identify the causes of problems confronting minority communities as the failings and inadequacies of black people themselves. Thus, much of the drug war of the 1980s was directed toward getting black people to "just say no." The problems of births out of wedlock and the rise of female headship seemed to lie in the permissiveness and lack of personal responsibility among black youth, who needed more of a middle-class set of values to set them right. Crime and joblessness were also seen as the consequences of misdirected motivations and lower-class values.

From the policy analyst's point of view, the root of black communities' poverty and hopelessness seemed to be rested in a pathological set of self-defeating and destructive behaviors. The violence, the abuse, the damaging patterns of unproductive behaviors, all were seen as manifestations of a group pathology unprecedented in its persistence and incidence among black people.

This view of the 1980s, however, helped to justify inattentiveness to the mounting problems confronting minority communities and to support a more laissez-faire governmental response to these problems. If the problems of black crime, female-headed families, welfare and poverty are the consequence of moral failings of the black community, then the black community and not the federal government must be in the forefront in laying the path toward salvation for black people.

Were the adherents to this view racists and bigots? Were those who shared this vision all right-wing conservatives? No. Respected scholars at major research universities embraced this perspective. The mainstream black press, which has a conservative reputation, embraced readily the self-help rhetoric. And black churches, particularly the more fundamentalist in orientation that bloomed during the 1980s, unhesitatingly adopted this stance.

The 1980s policy retreat was from two earlier public policy approaches towards blacks in the post-Civil Rights era. The first, which actually had its roots in the 1950s, was an approach that viewed blacks as deficient in skills and knowledge who needed to be assisted by the federal government through education and training programs. The second arose, surprisingly, out of the Nixon Administration in the form of the ill-fated family assistance plan. The plan later was revived and enacted with vigor in another form throughout the 1970s: the transfers approach. Blacks were poor because their incomes, for whatever reason, fell below the poverty line. Thus, to reduce poverty we needed only transfer incomes from the non-poor to the poor. Unfortunately, policy analysts belatedly learned that there may be some disincentives involved in such redistribution. Some also questioned whether in fact it was desirable to redistribute to the poor because they didn't deserve a handout.

This persuasive retreat from the historic dependency of black communities on the federal government was widely supported by an impressive range of intellectuals and grass-roots community activists alike. This retreat was substantially accelerated by the failure of earlier public policy approaches to resolve the dilemmas of the black community.

Now, with the current approaches to the drug problems seemingly contributing to the destruction of the black community, many blacks are worrying aloud. Is this an insidious plan designed to cause the rise in mortality rates of marginalized groups? Is this a plan to erode the traditional values and culture that support the development of a strong black community? Is the expected result of present drug policies the withdrawal from productive spheres of economic life, self-defeating and destructive behaviors by these marginalized groups? How is it that young males in the marginalized population are killing one another at such alarming rates that the ability of the population to reproduce itself is effectively eliminated?

What internationally recognized term would best describe this process? Of what would the United Nations accuse this nation? If these exterminatory policies were directed towards Jews in Poland, Armenians in turn-of-the-century Turkey, or Indians in Paraguay, the best word would be *genocide*.

In contrast, when the conditions facing blacks in America are described as genocide, attention shifts away from the facts of their continued marginalization and becomes an issue of semantics.

Such was the case last fall when a black producer of an ABC television documentary on the condition of black life alleged on Ted Koppel's *Night Line* that the drug-crisis in African-American communities "was the moral equivalent of genocide". What was meant, of course, was that national policies that neither stem the flow of addictive drugs into the poorest communities nor resolve the underlying poverty and distress that make the poor vulnerable to the lures of quick, cheap crack highs, amount to exterminatory policies. And, according to the United Nations Accord on Genocide--which the United States has never adopted--such exterminatory policies would be termed genocide. More than merely killing off the people, though, pertinent sections of the accord also suggest that eliminating the culture would be termed genocide as well.

Minister Louis Farrakan, of the Nation of Islam, has made this very claim, but most blacks in positions of leadership in white America have rushed to denounce this connection. In his speech announcing the formation of the Institute on the Black Male at Morehouse College, Louis Sullivan, Secretary of Health and Human Services, hastened to describe as nonsense these increasing calls of drug policy as genocide. Sullivan, whose agency oversees the units that compile data on black mortality and drug addiction, is in a particularly tight spot. He knows that the biggest killers of blacks are not crack cocaine or heroin; they are alcohol and tobacco. And he also knows that these two perfectly legal drugs are produced by industries that have contributed millions of dollars to worthy black causes and institutions, even as they continue to exploit minority markets.

Why, then, is it so important to denounce allegations of a conspiracy to kill blacks? Why is there a rush to discredit genocide theories? There are two reasons. First, black leaders themselves were the ones who called for the very policies that now have come to be regarded as genocidal. And second, the current stream of policies, when viewed from an historical perspective, seem to resemble others that have amounted to the same failures.

With regard to the first reason, one need only look at the fact that the chair of the Select Committee on Narcotics, who is black, has embraced wholeheartedly the national strategy of drug supply reduction. Sullivan's office leads the nation's treatment and drug rehabilitation efforts. The cities with the heaviest drug trade are cities with either black mayors or black police chiefs. This irony is not lost on the conservative critics who see the problem as a black community problem, with its leaders as much to blame as its masses.

The second reason stems from an unwillingness to admit failure. There seems to be a historical consistency of failed public policy developments in the black community. After virtually every major advance, we witness long-term backslides that cannot be regarded as simple accidents. After the Civil War, blacks enjoyed a brief euphoria of economic advancement only to be quickly struck down by the devastation of the declining Southern economy. After the World Wars, blacks earned new berths in industrial America, only to find that these jobs were too few to accommodate large numbers of young blacks entering the labor markets. And now, after the Civil Rights era, a new conservative tide has swept in with an aggressive attempt to focus on the failings of the black community itself. Now, too, when drugs seem to be the newest cancer of the black community, when it seems that drug policies are based on either blaming blacks for their addictions or worse on ignoring the victims in favor of vague and ambiguous international interdiction policies, some black observers have virtually given up in frustration. The frustration leads many blacks to view current drug policies as part of an historical pattern to marginalize the black community.

Leaders like Sullivan understand this frustration. Many of us have chosen to work from within the public sector in order to solve problems that we realize have critical implications for the survival of the black community. Part of the price of working from within, however, is that to be effective, to be heard, to be recognized and respected, we must denounce certain ideas, including the idea that current drug policies are genocidal.

There is little to choose from between Louis Sullivan's version of the world and Louis Farrakan's. But, both beg an important question: is there really a drug crisis in the black community?

Challenging Conventional Wisdom

Whether or not one accepts the view that drugs and drug policies are genocidal forces operating to kill off young black males, one thing seems certain: the drug problem in America is intensifying. It is out of control. And, there is little help along the way to stem the tide of this vicious killer. This contention seems to be the conventional wisdom in many policy arenas. Black leaders are in total agreement that there is a drug crisis in the black community.

Four statistics, however, challenge the view that there is a drug crisis in the black community and offer evidence that refutes that accepted notion. First, there is a nation-wide decline in the use of most drugs, particularly cocaine, the most widely discussed illegal drug in the nation. You can believe or not believe that these declines, measured in every national survey on record, are real. The same surveys reveal that with the exception of heroin, prevalence of use is lower among blacks than it is among whites. Figure 1 shows clearly that while the actual

prevalence of drug use differs among groups, since the mid-1980s there has been a decline in drug use among young people in the non-institutionalized civilian population. For example, among high school seniors cocaine use, as measured by the percent who used cocaine within the last 12 months, peaked at about 13 percent in 1985. It rose from about 7 percent in 1977 to a little over 12 percent in 1981. After a decline in the early 1980s, cocaine use rose again in 1984. The post-1985 decline appears to have been sharp and continued until 1988, the year for which the most recent data were available.[1] Cocaine use among college students, higher than that among high school seniors, also showed a drop in the mid-1980s.[2] Cocaine use among all aged 18-25 years, generally higher than that of the subset of high-school seniors and college students, appeared to peak in the early 1980s and then to decline throughout the mid-1980s.[3] Not including the slight increase in regular hard drug use among criminals from the late 1970s to the 1980s, the patterns of occasional use of cocaine among young people appears clear: there was a sharp reduction in use from the mid-1980s on.[4]

Furthermore, drug use rates tend to be lower among blacks than among whites. While in 1985 12.4 percent of whites reported having ever used cocaine, only 9.9 percent of blacks admitted cocaine use. The gap was narrower for the response to whether cocaine had been used within the past 12 months. For whites the rate was 6.4 percent, for blacks it was 6.2 percent.[5] By 1988 drug use among blacks and whites was down. Whites reported having ever used cocaine at a rate of 10.8 percent; the rate for blacks was 9.3 percent.[6] This racial differential in prevalence of drug use is replicated for most other drugs and alcohol as well. It confirms, moreover, that the decline in occasional drug use occurred in both the black and white communities.

The second piece of evidence addresses the question of the risks associated with street-level drug sales. Figure 2 shows that drug arrests per 100,000 population soared from about 250 in 1979 to 400 in 1987. After a brief decline during the late 1970s, the arrest rate for drug abuse violations increased steadily throughout the 1980s.[7] There are two aspects of risk included in the drug abuse arrest rate. One involves risks to sellers. The other largely involves risks to users, but indirectly affects sellers as well. Sellers are infrequently caught in the act of consummating a sale. But possession of drugs, a crime that often entraps drug users, is a charge frequently leveled against suspected sellers caught only with drugs in their possession. Thus, the combined measure of risk that captures these two indicators ought to reflect accurately the trend in risks faced by sellers alone. And this risk, unquestionably, increased throughout the 1980s.

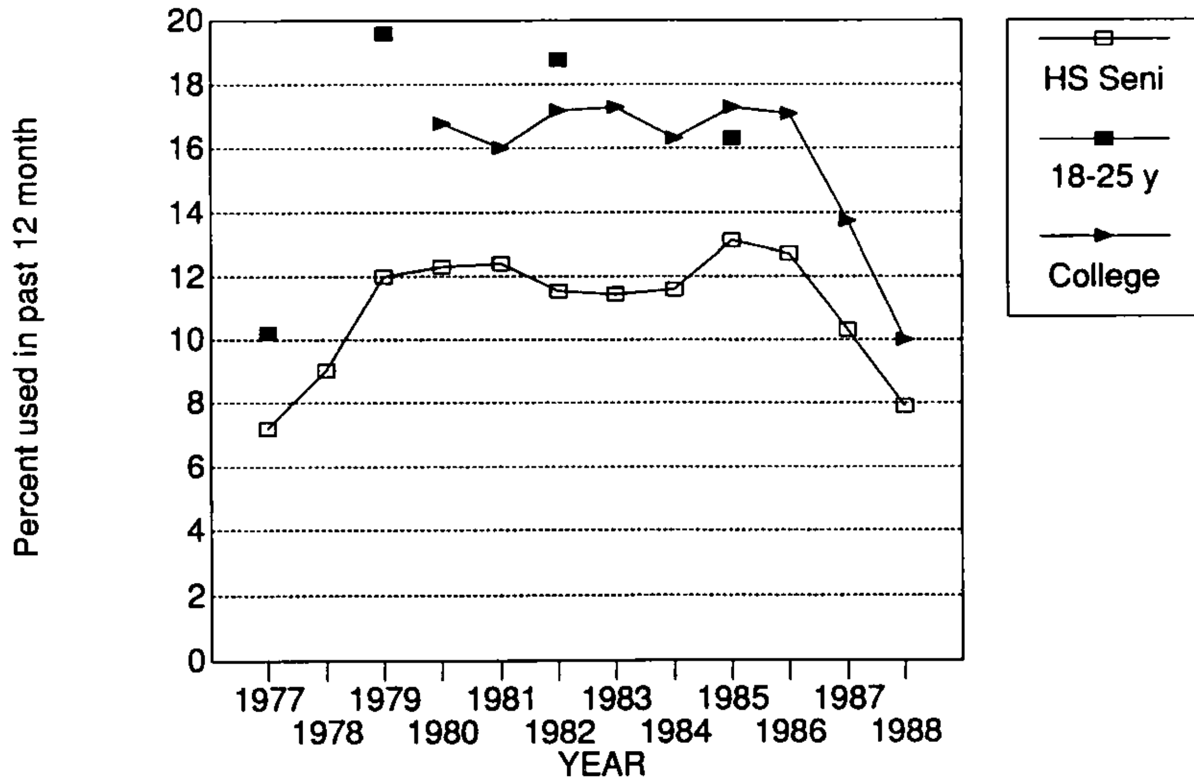


Figure 1

Figure 3 underscores a third aspect of changing drug markets over the past decade. Cocaine prices have dropped sharply since the mid-1980s. The price of a pure gram of cocaine dropped from a high of $780.00 in 1979 to a low of $142.00 in 1987. The biggest decline occurred between 1982 and 1983, when the price dropped from $600.00 to $314 per pure gram. Others have noted that *price increases* ought to indicate the effectiveness of law enforcement efforts to combat drug sales and curb drug consumption.[8] However, the street-level price of cocaine is another indicator. Assuming the costs remain constant for dealing drugs--the purchasing from intermediate-level suppliers, and related risks--a fall in the street-level price of drugs will reduce the profitability of drug dealing. The drop in cocaine consumption shown in Figure 1 is consistent with a fall in drug demand that could explain the decline in drug prices; the increase in drug arrests could also explain the fall in drug demand, contributing to a decline in street-level prices. Together with the increased risks to sellers due to increased drug arrests, the fall in drug prices at the street-level suggests a reduction in the profitability of the drug trade, at least to street-level sellers.

How, then, does one interpret anecdotal evidence of escalating involvement by young black males in street-level sales of such drugs as crack and cocaine? The drug trade, it seems, has become *less profitable* in recent years because of the decline in demand, the increase in risks, and the fall in street-level prices. All other things being equal, fewer new sellers should be entering this market, not more.

Yet, just as coke prices have fallen, demand has dropped and the risks have escalated, the relative attractiveness of illegitimate activities among young black males has surged. Figure 4 displays the ratio of black to total median weekly earnings among full-time, year-round employees among males ages 16 to 24. The obvious implication of this is that the relative attractiveness of the drug trade for young black males cannot be the low risks, the high profits, or increased demand for these drugs: the risks are rising, prices and presumably profits are falling, and demand has dropped. The attractiveness of drug trade must arise from the relative decline in legitimate employment.

Or, perhaps the pundits, who claim that drugs are infesting the black community at alarming rates and serve as a new and growing outlet for the employment and entrepreneurial efforts of young black males, are simply mistaken. In particular, how does one reconcile the fact that drug consumption seems to be declining while the black community's drug problem seems to be on the upswing? We answer this question by considering the various partial equilibrium models that could explain the conventional wisdom.

DRUG ARREST RATES

1977 - 1987

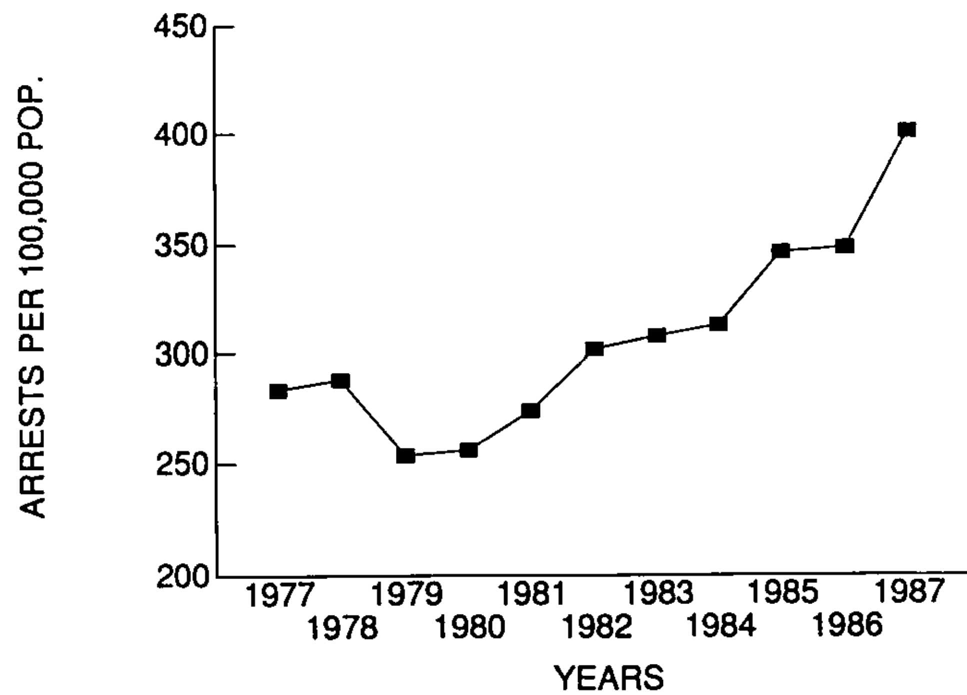


Figure 2

Figure 3

COCAINE RETAIL DRUG PRICES

(PRICES PER PURE GRAM) 1977-1987

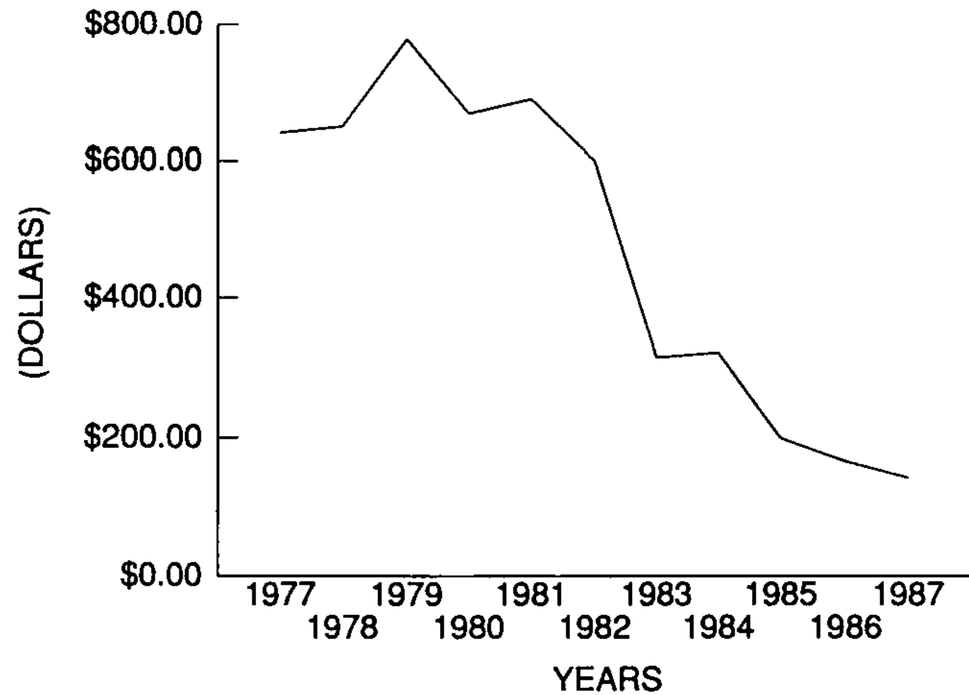
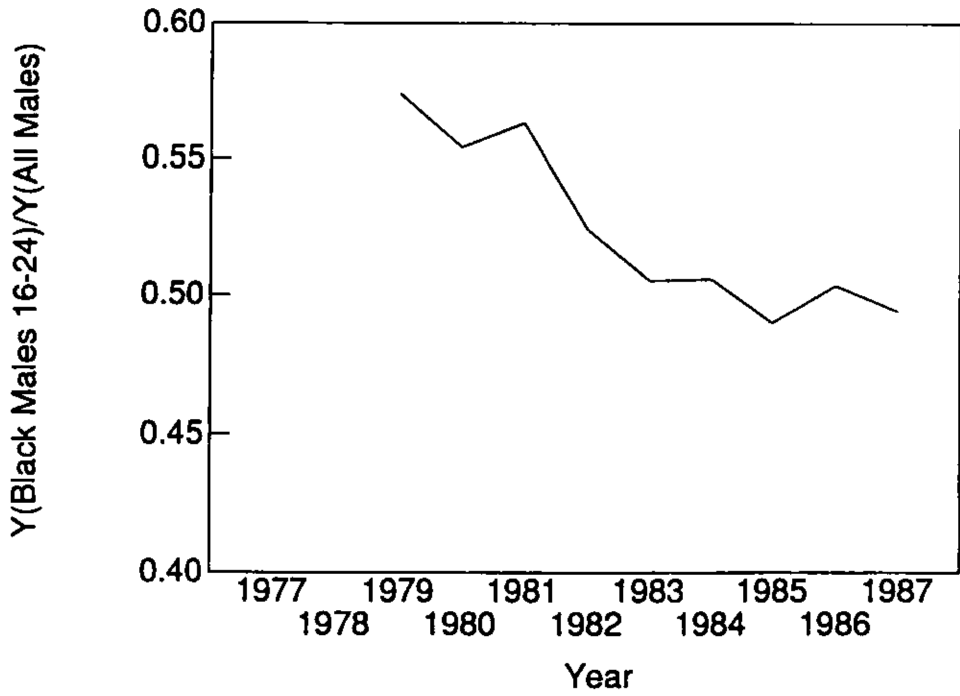


Figure 4

Relative Earnings of Young Black Males

1979-1987



Partial Equilibrium Models

Price reductions in simple supply and demand models generally occur because of declines in demand or increases in supply. We will consider three cases, two capture parables of different viewpoints about what happened to cocaine markets in the 1980s. The third case describes a paradoxical result.

The first case considers the following parable: The Reagan Administration declared war on drugs. It increased drug arrests for the sale or manufacture of drugs by more than 180 percent, increased efforts to stem the flow of drugs into the country by vigorous interdiction efforts and seized increasing amounts of drugs at the different levels of the distribution chain. The expected effect: a reduction in drug supply.

Figure 5 shows this scenario. Demand, D, remains unchanged. Supply falls, shifting from S to S'. Equilibrium drug consumption drops from q^1 to q^2. This is consistent with the evidence of Figure 1. Yet, as a result of the reduction in supply and the fall in equilibrium consumption, the price rises from p^1 to p^2, in contradiction to the evidence provided in Figure 3. This scenario, upon which much of the Reagan year's "War on Drugs" was fought, is implausible.

A second case considers this parable: Colombian drug-lords and elected officials blamed the U.S. drug problems on the unsatiable demand for cocaine among American consumers. The alleged effect: increased drug demand and increased consumption. Figure 6 sketches a scenario consistent with this parable. Generally, increased demand *raises* price. One situation, however, wherein increased demand lowers equilibrium price arises when there is forward falling supply. This might stem from an industry with increasing returns to scale: larger outputs can be produced at lower average costs. There is much that can be said about the prospects of a drug-cartel operating in an increasing returns to scale environment. And, such an industry structure is quite consistent with and conducive to the formation of cartels and criminal monopolies. Yet, as Figure 6 reveals, the result of an increase in demand in such a world would be an *increase* in drug consumption. When demand shifts from D to D', price falls from p^1 to p^2, but drug consumption *increases* as a result, from q^1 to q^2. The Colombian parable is not consistent with the evidence: cocaine consumption fell. The notion that the nature of America's drug problem is rising demand, while initially plausible in the international context of criminal monopolies and cartels, simply fails to pan out in the final analysis.

A clue remains to unravel this paradox: falling drug prices and drug consumption accompanied by an apparent increase in black participation in the drug trade. This clue comes when one inspects data on drug addiction and frequent drug use. Whereas white drug use is generally greater than that among blacks, one measure shows a different

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A clue remains to unravel this paradox: falling drug prices and drug consumption accompanied by an apparent increase in black participation in the drug trade. This clue comes when one inspects data on drug addiction and frequent drug use. Whereas white drug use is generally greater than that among blacks, one measure shows a different pattern. Black addiction rates to heroin and cocaine are generally higher than those for whites. The racial gaps in rates of regular use of cocaine and crack rose in the latter part of the 1980s, despite the fact that black and white drug use declined overall.[9] Moreover, there is scanty evidence to suggest that drug addiction among those not in the populations covered by the national surveys--the homeless, the institutionalized, the imprisoned--is likely to be on the rise. To the extent that blacks are over-represented among those at-risk groups excluded from the conventional surveys, it is possible that overall black addiction rates have increased as well.

CASE 1: DEMAND REMAINS UNCHANGED

SUPPLY DECREASES

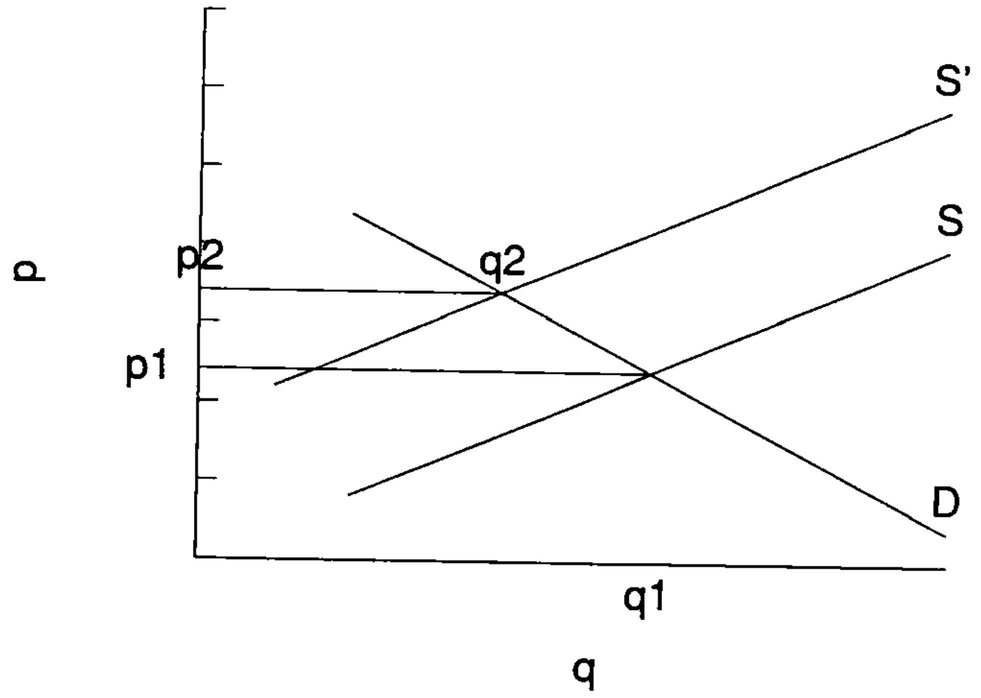


Figure 5

Figure 6

CASE 2: DEMAND INCREASES

FORWARD FALLING SUPPLY

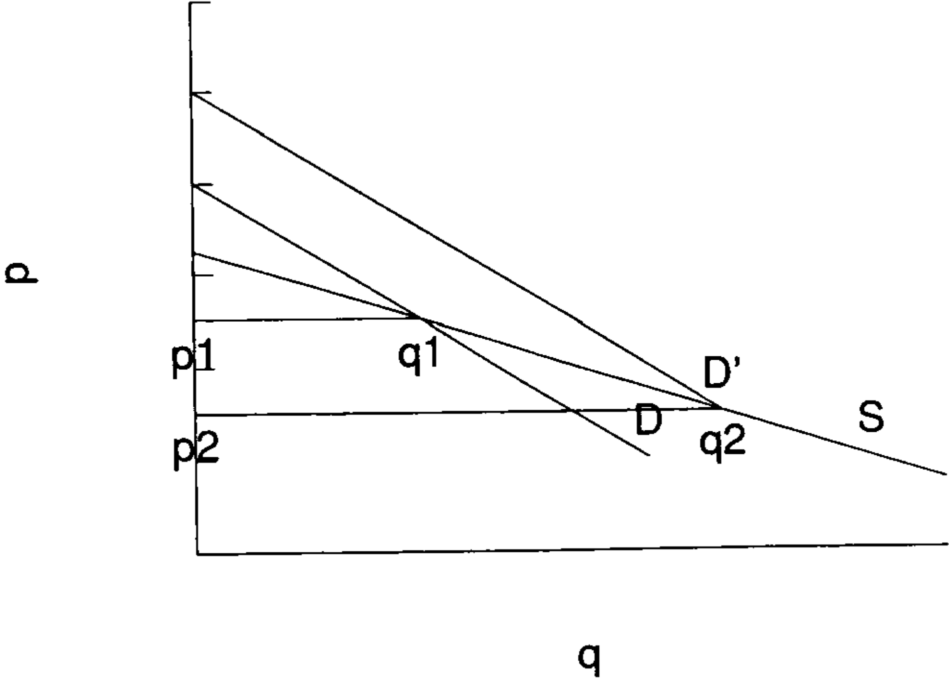
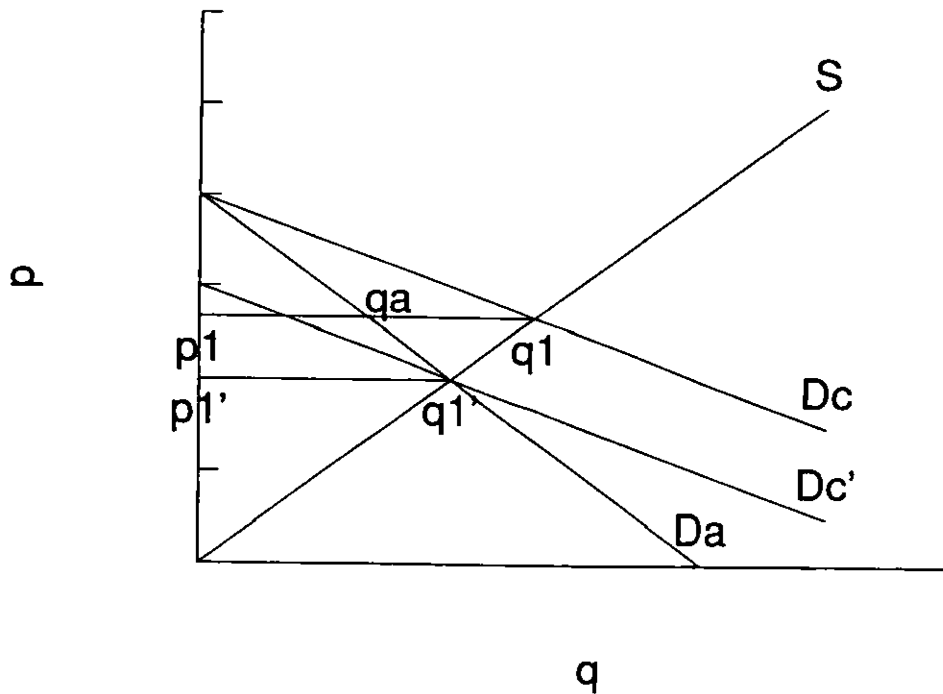


Figure 7

CASE 3: DEMAND DECREASES

SUPPLY REMAINS UNCHANGED



This suggests two types of demand for drugs. One demand comes from occasional users. This demand is likely to be very elastic and extremely responsive to price changes. The fall in price and the reduction in consumption among casual users during the 1980s is consistent with a fundamental shift in their demand for drugs: casual drug demand fell. This scenario, displayed in Figure 7, suggests a shift in drug demand among these users from D_c to $D_{c'}$, causing prices to fall from p^1 to $p^{1'}$ and causing consumption to decline from q^1 to $q^{1'}$.

Since casual users dominate the market, the drop in demand facilitated the fall in market prices. Drug addicts or frequent users must pay the market price. Their demand curve, represented by D_a, is steeper than the demand faced by casual users. In the short-run at least, one would *not* expect there to be much responsiveness to price changes among addicts.[10] At price p^1, cocaine addicts will consume q_a. When casual cocaine demand falls, lowering the market price to $p^{1'}$, addict consumption increases to q'. Admittedly, this is not a massive increase in consumption because of the inelasticity of the addict demand. But it is notable precisely because addict consumption increased at the same time that casual use declined.

Herein lies a plausible third explanation for the seemingly paradoxical rise in black drug activity when the drug market is becoming less profitable. Young black males, facing diminished legitimate economic opportunities, are attracted to this declining market for two interrelated reasons beyond their ill fates in the legal market. First, black consumers, more likely to be addicts than white consumers, represent a segmented market. With heavy concentrations of black consumers in segregated areas of the urban core, a geographical monopoly exists. With declining profitability of the drug trade generally, white traders exit the market leaving the inner-city trade largely to blacks and other minorities who reside there. Young black males, often school drop-outs, unemployed, or out of the labor force altogether, seize these entrepreneurial opportunities which may seem superior to their limited prospects in legitimate pursuits. Second, with the reduction in prices, addict consumption increases. Black addicts, often both buyers and sellers, pose specialized risks for sellers from nonblack neighborhoods. The reduction in drug prices, then, has the effect of generating more business for black sellers, despite the fact that the overall decline in prices is due to the reduction in drug demand, and therefore a fall in market-wide drug sales. Young black males simply sell to other young blacks in their own neighborhoods, oddly contributing to an increased flow of goods and services akin to what happens when exogenous increases in legitimate spending occurs.

Is there really a drug crisis?

If the third case is to be believed, then the notion that drugs are the central issue confronting minority communities is challenged. Not only is it not obvious that the cause of the myriad of problems confronting in particular young black males is the drug trade, it is also not obvious that that drug trade is economically harmful to the black community. Stated in another way, the problem stems not from the particular product that happens to be the source of the present illegal entrepreneurial pursuits of inner city residents. Instead, the problem stems from the failure of alternative routes toward fulfillment of existing entrepreneurial talents among blacks. In the 1980s, the illegal product was crack and low-priced cocaine. In the 1970s, the illegal product was heroin. In much of the post-War World II period, gambling and numbers represented the target of unfulfilled entrepreneurial talents of bright inner-city residents. Despite the changing product, the scenario remains starkly similar: conventional routes toward fulfillment of entrepreneurial talents are blocked for blacks; segregation of blacks offers a geographical monopoly in certain criminal activities, opening illegal opportunities for black residents; changes in over-all market structures can have perverse impacts on black communities. The influx of low-priced heroin from Southeast Asia during the 1970s, for example, helped to expand heroin consumption among low-income blacks and thus to open sales opportunities for other blacks in low-income neighborhoods. Quite simply, the problem is not drugs.

The problem is the market. Illegal opportunities, shunned by many outside of the black community because of high risks and low profitability, represent viable alternatives for inner-city residents. These opportunities arise because of limited competition created by residential segregation; they are made more attractive by an absence of realistic legal business alternatives. The issue goes far beyond whether there are suitable job opportunities for these inner-city residents. Some people do not want to be workers. They want to be owners. Selling drugs in the 1980s, like running numbers in the 1950s, represented the inner-city version of being your own boss. While white electrical engineers dream of leaving their jobs at IBM to start their own computer design firms, black drug pushers yearn to make a big buy so that they can acquire their own regular customers and deal with one less middle-man in the drug distribution network. Both want to be their own men. The difference is that the product the black youth sells, which happens to be illegal and unquestionably dangerous, will cause him to die young and to help kill off many other young men as well. That is why so many black commentators are quick to link the current drug phenomenon to genocide.

Unfortunately, calling this process genocide does little to bring attention to the fact that in earlier eras, when the illegal product was less lethal, exactly the same causes were at work: few alternative economic opportunities in legitimate pursuits. But more to the point, calling the Reagan-Bush administration's national drug policy genocidal because, by concentrating on reducing the supply of drugs, it raises prices, thus increasing competition, which then causes drug-related violence, misses an important factual point. Drug prices did not rise as one would expect when supply-side policies work; competition in inner-city areas probably declined because there were, undoubtedly, exits from the market.[11] Drug use dropped even among habitual users in the general population, and among blacks drug use declined as well. The decline, to be sure, was not because of Reagan-Bush administration policies. But, that is all the more reason to reject the claim that these policies are genocidal. Or, for that matter, all the more reason to reject the notion that the real problem is drugs.

In conclusion, then, we see in the so-called drug crisis confronting black communities the evolution of misguided or intentional policies that have deleterious impacts on black communities. For whatever the reason, drug demand fell, drug prices declined, and overall risks in the drug trade increased. The impact on the black community has been perverse: it has increased the prevalence of addiction and the opportunities for those who would sell to these addicts. Yet, in this particular case, focus on the apparent culprit--drug markets--blinds us from observing a broader, more far-reaching policy failure: the failure to formulate policies to nurture and reward the existing entrepreneurial talents of inner-city residents for legitimate markets. Decades-old policies intended to provide these people with basic skills so that they could be workers continue even today. And yet, these would-be-workers have discovered, like cohorts before them, that the illegal market can nurture and reward handsomely.

END NOTES

[1]U. S. Department of Justice, *Drugs and Crime Facts, 1989*, (Washington, D.C.: Government Printing Office, 1990), p. 17. For discussion of sample design and the reliability and validity of responses, and compilation of data, see U.S. Department of Justice, Bureau of Justice Statistics' *Sourcebook of Criminal Justice Statistics, 1988*, (Washington, D.C.: Government Printing Office, 1990). Table 3.74 p. 356. The original source is U.S. Department of Health and Human Services, National Institute of Drug Use, *Illicit Drug Use, Smoking, and Drinking by America's High School Students, and Young Adults, 1975-1987*, by L.D. Johnson, P . O'Malley and J. G. Bachman. Washington, D.C.: U.S. Government Printing Office, 1989.

[2]Data for college students come from the same study as for high school seniors, as part of a follow-up survey of respondents 1-4 years out of high school.

[3]Data come from U.S. Department of Health and Human Services, National Institute of Drug Abuse, *National Household Survey on Drug Abuse, 1988* (Washington , D.C.: Government Printing Office, 1990) and earlier years. Survey results refer to the years 1977, 1979, 1982, 1985 and 1988. Intervening years were extrapolated. An important distinction exists between the NIDA estimates of young adult use and the previously discussed estimates based on high school seniors and the follow-up surveys. The young adult population in the NIDA is derived from a national probability sample of households in the United States and *excludes* persons living in group quarters or institutions. Thus, it excludes persons living in college dormitories, as well as those in jail or prison, transients and the homeless. The *Illicit Drug Use* survey (Washington, D.C.: Government Printing Office, 1989) includes high school graduates 1 to 10 years beyond high school . Thus, it *includes* college students as well as those living in dormitories. Since data on the latter measure are only available for 1986 and 1987, the former measure is used in figure 1.

[4]There is no comparable time series on criminal drug use. Two surveys of state prisoners, however, yield estimates of hard drug use in 1979 and 1986. These surveys show that regular hard drug use rose from 33.4 percent in 1979 to 35 percent in 1986. Bureau of Justice Statistics, *Sourcebook*, Table 6.44, p. 623.

[5]Ibid., 3.92, 366.

[6]National Institute of Drug Abuse, *National Household Survey*, Table 4-B, p. 30.

[7]Drug abuse violations include state and local offenses relating to the unlawful possession, sale, use, growth, and manufacture of narcotic drugs. In 1988, the rate rose again to 449.9 per 100,000 inhabitants. In that year 27.4 percent of those arrests were for possession. The vast majority of sale or manufacture arrests were for herion, cocaine and their derivatives. U.S. Department of Justice, Federal Bureau of Investigation, *Uniform Crime Reports for the United States, 1988,* (Washington, D.C.: Government Printing Office, 1989) pp. 167-169, p.320.

[8]Peter Reuter and Mark A. R. Kleiman, "Risks and Prices: An Economic Analysis of Drug Enforcement, "Vol. 7, in *Crime and Justice: An Annual Review of Research,* ed. by Michael Tonry and Norval Morris (Chicago: The University of Chicago Press, 1986), pp. 289-340.

[9]In 1985 3.2 percent of blacks reported using cocaine within the last 30 days; 3 percent of whites reported use over the same period. In 1988, 2 percent of blacks reported using cocaine in the last 30 days; 1.3 percent of whites reported use over the same period. National Institute of Drug Abuse, *National Household Survey,* Tables 4-B & D, pp. 24-25; Bureau of Justice Statistics, *Sourcebook,* Table 3.82, p. 366.

[10]This perspective is disputed by Reuter and Kleiman who assume that herion users are more likely to be casual users, but that herion demand seems to be more elastic than marijuana demand. Yet, if one assumes that within a given drug market there are both addicts and casual users, then it seems more reasonable to model these demands separately. In such a case, one would be hard pressed to explain how or why addicts should be *more* responsive to price changes than casual users.

[11]Parenthetically, black homocide rates did not soar, as is conventially thought. Black male homocide rates fell steadily throughout the mid to late 1970s, peaked in 1980, dropping from .66 per 1000 in that year to .48 per 1000 in 1985. In the late 1980s, the rate increased, only to fall again.

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Social Structure and the Health Status of Black Males

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Four days after Martin Luther King's birthday, this year, a report appeared in the New England Journal of Medicine that highlighted the seriousness of the crisis in terms of the health status of black males (McCord and Freeman 1990). This study calculated mortality rates for African Americans in the central Harlem health district of New York City, and compared them to those of whites. Between the ages of 25-44 black males in Harlem are 6 times more likely to die than white males in the U.S. Cardiovascular disease, cirrhosis of the liver, homicide and cancer are the main causes of the excess deaths. Moreover, the life expectancy of adult males in Harlem is lower than that of males in Bangladesh. Bangladesh is categorized by the World Bank as one of the poorest countries in the World.

This study also profiled the socioeconomic conditions in Harlem. The median family income in Harlem in 1980 was $6,497. That compares with $16,818 for New York City; $21,023 for the U.S. and $12,674 for all African Americans in the U.S. Harlem is 96% black and 41% of the population lives below the poverty line. The population of Harlem declined from 233,000 in 1960 to 121,905 in 1980. During this same period the death rate from homicide increased by almost 400 percent.

Today, I would like to give an overview of some of the critical health issues facing black men. I would particularly like to emphasize that the health problems confronting the African American community cannot be separated from the socioeconomic conditions in the black community. Disease is rooted in social structure. I will illustrate this relationship by discussing socioeconomic differences in health status, the role of medicine as a determinant of health status, race differences in high blood pressure, and the social distribution of health behaviors.

State of Black Health

The Secretary's Task Force on Black and Minority Health reported that there are nearly 60,000 excess deaths among blacks every year (U.S. Department of Health and Human Services [DHHS] 1985). That is, there are 60,000 deaths among blacks each year that would not occur if blacks experienced the same death rates as whites. Now, the death rates for whites are not necessarily an ideal standard of comparison; there are thousands of avoidable deaths among whites. At the same time, this comparative data provides one way of highlighting the health

problems of the black population. Compared to whites, black males are 1.4 times more likely to die of cancer; and two times more likely to die of cerebrovascular disease (stroke and heart disease), diabetes and cirrhosis of the liver. Black males under age 45 have rates of death from tuberculosis that are 17 times greater than that of whites; hypertension 10 times, homicide 7 times, and anemias 6 times greater.

In terms of mental health, blacks are disproportionately exposed to social conditions considered to be important antecedents of psychiatric disorder but blacks do not have higher rates of mental illness than whites. The latest and best evidence comes from the National Institute of Mental Health's Epidemiologic Catchment Area Program (ECA) studies. The ECA program involved assessing rates of mental disorder in 5 sites across the country using criteria based on the Diagnostic and Statistical Manual III (DSM-III). In addition to sampling large community populations, the ECA program also sampled persons residing in institutional settings such as correctional facilities and nursing homes. In the community 14% of black males had a psychiatric disorder compared to 13% of white males. Twenty-seven percent of black males in institutions had a psychiatric disorder compared to 26 percent of white males. Blacks historically have had lower suicide rates than whites. Recently, there has been an increase in suicide rates for black males but the age patterning of suicide varies across race (Griffith and Bell 1989). For white males the highest suicide rates are for those over age 65; for black males suicide peaks in the 25-34 age group. The increase in suicide among young black males probably reflects the growing sense of hopelessness that characterizes their opportunities in this society.

The overall evidence on black mental health clearly indicates that there are important resources and strengths in the black community that is protecting the community from the onslaught of pathogenic stressors. One of these important and neglected resources is probably the black church and renewed research attention should be given to the possible health promoting functions of religious involvement.

Socioeconomic Status and Health

It is important that we recognize that the high rates of disease and death in the African American community is part of a larger pattern. Low socioeconomic status is a powerful and pervasive predictor of a broad range of health outcomes (see Williams 1990 for a recent review). Our earliest records indicate that poor people had lower life expectancy and more health problems than the wealthy. This relationship has not changed over time. Despite general improvements in health status, broad based social and economic change, and advances in health care technology and the delivery of medical services, there has

The health problems of black males are thus part of a larger, fairly universal phenomenon in which poverty is associated with increased rates of disease and death. This general trend may be exacerbated among African Americans because of their exposure to both poverty and discrimination.

Medical care

Inadequate access to medical care is one of the sources of the racial disparity in health status. Recent national data indicate that African Americans are less likely than whites to have health insurance, to have a regular source of care and more likely to be dependent on emergency room and hospital clinics (Blendon et al. 1989). Blacks are also more likely than whites to be dissatisfied with the medical care received. It is frequently assumed that simply improving access to medical care will eliminate disparities in health. The available evidence suggests, though, that the attention given to medical care is disproportionate to its importance as a determinant of health status.

Medical care can explain no more than ten percent of the variation in health status (U.S. Department of Health, Education and Welfare [DHEW] 1979). Some studies find that increased access to medical care is either unrelated to health or leads to a deterioration of health status (Diehr, Richardson, Shortell and LoGerfo 1979; Newhouse and Friedlander 1980). Even those studies that find a positive impact for physician services, note that the effect of medical care is small when compared to that of non-medical variables (Williams 1975, Hadley 1982). Hadley (1982) notes for example that a reduction in cigarette consumption would do more to improve health than an increase in medical expenditure.

As surprising as these findings may seem they are consistent with the evidence from other researchers that, to a large degree, medical care is not an important determinant of health status (McKeown 1979; Powles 1973). It has been demonstrated, for example, that improvements in health status in the last 150 years, in both the U.S. and the U.K., have been due more to improvements in the standard of living and the environment (water supply and sanitation) than to personal medical care (McKeown 1979; McKinlay and McKinlay 1977). These researchers indicate that most of the decline in the infectious diseases (that were the leading causes of death in the 19th and early 20th centuries) occurred before the advent of effective medical treatment for those illnesses. Medical economists have similarly noted that non-medical variables are more important determinants of health status than medical care. Specifically, greater reductions in morbidity and mortality are possible through additional expenditures on formal education than through additional expenditures on medical care (Auster,

been no narrowing of the SES differential over time. A review of mortality data from England, France and the United States concluded that there has been no change in the excess mortality of poverty populations in any of these countries since the Second World War (Behm and Vallin 1982).

The case of England and Wales is especially instructive. It was expected that the combination of post-war economic growth and the introduction of the National Health Service would eventually lead to the elimination of the SES gradient in health status. In contrast, recent data reveal that SES differences in England and Wales are widening (Hollingsworth 1981; Wilkinson 1986). Moreover, differential recruitment of immigrants into the lower SES groups in the U.K. does not account for these findings (Marmot and McDowall 1986). Instead, while health status has improved for all groups in Britain, the higher SES groups have experienced greater improvement than their less prosperous peers.

This persistence of SES differentials in health outcomes is not limited to the U.S., England and France; SES differences in health status are a fairly universal phenomenon. Recent reviews of this literature reveal that SES differences in mortality exist in Norway, Sweden, Denmark, Finland, Germany, the Netherlands, Australia, New Zealand, Canada, Japan and several Third World countries (Marmot, Kogevinas and Elston 1987; Haan and Kaplan 1986; Department of Health and Social Security [DHSS] 1980).

The power of SES as a determinant of adverse changes in health status is also illustrated by the secular trends that have been observed in the social distribution of certain diseases. That is, in the history of particular diseases, even when an illness was initially more prevalent among the higher SES groups, over time it becomes more prevalent among the less affluent. Coronary heart disease (CHD) is an example of this phenomenon. During the 1950s, the prevalence of CHD and CHD risk factors was positively associated with social status (Taylor 1967). As these risk factors (serum cholesterol, smoking, blood pressure and a sedentary lifestyle) became more pervasive throughout the society, the relationship between social status and CHD changed from a positive to an inverse gradient (Morgenstern 1980). AIDS is an instructive recent example. Most of the initial AIDS patients were white, middle class, homosexual or bi-sexual males. Currently, the incidence of this disease among black and Hispanic homosexual males is two to three times higher than among whites; for heterosexual males (the majority of new cases), the rate is 20 times higher among blacks and Hispanics than among whites (Peterson and Marin 1988).

Levenson and Saracheck 1969; Fuchs 1979). The earlier noted continuing occurrence of SES differences in health status in the countries of Western Europe, where inequalities in access to medical care have been virtually eliminated, is also consistent with a limited contribution of medical care to health status.

Studies of the recent decline in mortality from coronary heart disease lend strong support to this argument. Goldman and Cook (1984), for example, analyzed the decline in ischemic heart disease between 1968 and 1976. They found that changes in lifestyle saved more lives in the period studied than all medical interventions combined. They estimated that while reductions in cholesterol and cigarette smoking were responsible for 54 percent of the decline in heart disease mortality, medical interventions (coronary care units, pre-hospital resuscitation and care, coronary artery bypass surgery, medical treatment of clinical heart disease and the treatment of hypertension) were responsible for only 40 percent.

Although differences in medical care resources will not explain differentials in disease, and medical care is less important than generally assumed, equality of access to medical care is still an important and desirable goal and is crucial to arresting further deterioration of the health status of African Americans. There are several ways in which medical care can be crucial to promoting health and preventing disease. Preventive medical care, throughout the life cycle but especially during infancy and childhood, is critical in preventing illness. Similarly, adequate prenatal care can play a role in preventing infant mortality and other adverse pregnancy outcomes (Nersesian 1988). Finally, early intervention in the course of a disease and medical management of chronic illness can affect both survival rates and the quality of life. Blacks with cancer and AIDS, for example, have shorter survival times than whites (Haan and Kaplan 1986; Primm 1987). This is probably due to race differences in the quality of care including later diagnosis and treatment of these diseases in blacks.

It also appears that medical care has a larger impact on the health status of lower SES groups than on their higher SES peers. For disadvantaged groups faced with multiple vulnerabilities, medical care may be the only health protective resource. In contrast, in groups that enjoy many social and environmental resources, the additional contribution of medical care may be negligible. Thus, prenatal care, while critical to a poor mother with multiple risk factors for adverse pregnancy outcomes, has little positive effect on a middle class mother in favorable social circumstances (Nersesian 1988). The medical treatment of hypertension is also more effective in blacks than whites (DHHS 1985). Similarly, Hadley (1982) indicates that additional

medical care will lead to larger reductions in mortality rates for blacks than for whites. Thus, we must continue to improve health care delivery in the black community. At the same time, we must recognize that more health care alone will not solve the health problems in Black America.

Race and Blood Pressure

The problem of hypertension provides a particularly potent illustration of the social origins of illness. High blood pressure is one of the most serious health problems in the black community. Hypertension is the major risk factor for cerebrovascular disease (stroke), and a major risk factor for coronary heart disease and kidney disease--three diseases that are important contributors to the excess morbidity and mortality in the black population. Heart disease is the most common cause of death among blacks and occurs more frequently among blacks than among whites (Cooper and Simmons 1985). Mortality rates from stroke and end-stage renal disease are 3 to 17 times higher for blacks than whites (Check 1986; U.S. Department of Health and Human Services [DHHS] 1985).

Epidemiologic studies have long observed that blacks have higher average levels of blood pressure than whites and are twice as likely as whites to have hypertension (Stamler, Stamler and Pullman 1967). National studies indicate that there is an age patterning to the race differences in high blood pressure. Blood pressure levels increase with age for both blacks and whites. However, up through adolescence there is no racial disparity in blood pressure. It is during early adulthood that blood pressure increases more dramatically in blacks than whites, so that racial differences are clearly apparent by age 25 (U.S. Department of Health, Education and Welfare 1977).

Genetic and physiologic explanations alone are unlikely to explain race differences in blood pressure. Unlike the U.S., where blood pressure levels increase with age for both blacks and whites, numerous societies exist where blood pressure levels remain stable over the life course (James 1987). Thus, genetic explanations appear unlikely to explain why the race difference in blood pressure becomes evident only in adulthood. Blood pressure levels of African people in West Africa are lower than those of blacks in the U.S. (Gillum 1979). However, when black populations in Africa and other traditional populations in third world countries move from their original communities to large urban centers, there is a rise in blood pressure (James 1987). It appears then, that to the extent that genetic and physiological differences exist, they are likely to operate by interacting with other environmental variables to affect blood pressure levels.

Stress and Social Conditions. The finding of a positive association between urbanization/westernization and blood pressure levels clearly suggests an important role for environmental stress in hypertension. Animal studies reveal that experimentally induced stress can cause chronic elevations in blood pressure (Brody et al. 1987). This stress-induced hypertension occurs most frequently when experimental animals have a predisposition to high blood pressure. Studies of human populations have not uniformly employed the same level of methodologic rigor as the animal experiments, but the overall weight of the evidence from these studies clearly implicates stress as at least a precipitating agent in hypertension.

Studies of occupational groups characterized by high levels of stress (such as air traffic controllers, and urban bus drivers) indicates that these groups have higher levels of blood pressure than other comparable groups (Brody et al. 1987; Krantz et al. 1987). Other studies reveal that blood pressure increases in factory workers when they lose their jobs (Kasl and Cobb 1970). Attempts have also been made to identify the specific characteristics of working environments that are predictive of increased hypertensive risk. A review of this literature indicates that the working conditions strongly associated with a high risk of hypertension are high job demands combined with low control (Krantz et al. 1987). The U.S. occupations identified as falling into this category include clerks, laborers, and assembly line workers. All of these occupations are those in which African Americans, in particular, and persons from the lower socioeconomic groups more generally, are likely to be overrepresented.

The work of Harburg and colleagues (Harburg, Enfurt, Chape, Hauenstein, Schull and Shork 1973a,b) provides striking evidence that stress in the social environment is positively associated with blood pressure and can explain a substantial part of the race differences in hypertension. These researchers characterized census tracts in Detroit as either high or low in stress. High stress areas were defined by high levels of economic deprivation (low median income and years of formal education), residential instability, marital instability and crime. Low stress census tracts had the converse conditions. The study found that persons living in high stress areas had higher levels of blood pressure than persons in low stress areas. This association was stronger among blacks than whites. However, the blood pressure levels of black males in low stress areas did not differ from those of white low stress males. Other studies reveal that there is a positive association between blood pressure and specific stressors in residential environments, such as industrial nose, airport noise, traffic noise and overcrowding (Krantz et al. 1987).

Harburg and colleagues (1973b) also assessed the association between blood pressure levels and emotional response to being unfairly treated in two hypothetical situations. Holding anger in or feeling guilty about displaying anger were both positively related to blood pressure. Suppressed hostility (the combination of keeping anger in and feeling guilty if anger is expressed) was positively associated with hypertension among both black and white males. Moreover, coping patterns appeared to be constrained by the social environment. Men in high stress areas reported higher levels of suppressed hostility and greater use of keeping anger in than men in low stress areas (Harburg et al. 1973b). It is likely that persons who live and work under conditions of acute social and economic deprivation would be exposed to more anger-arousing social situations.

Research by William Dressler has documented an association between thwarted aspirations and high blood pressure. Dressler (1982) found a positive association between blood pressure and the active pursuit of material success among persons who lacked the economic resources to attain it. The classic studies of John Henryism and blood pressure by James and colleagues (James, Hartnett and Kalsbeek 1983; James, Strogatz, Wing and Ramsey 1987) provide further evidence that thwarted aspirations may play an important role in the high rates of hypertension in the African American population. John Henry was a strong but uneducated steel driver in a black American folktale who died of exhaustion immediately after conquering a mechanical steel drill. A high score on the John Henryism scale reflects an active orientation to cope with stress. In a sample of black men, James et al. (1983) found the highest blood pressures among men who scored high on the John Henryism scale but lacked the social and economic resources (had not completed high school) to facilitate their determined efforts to succeed. Subsequent research in a larger sample found that among African Americans who scored high on the John Henryism scale, persons of low SES were three times as likely to be hypertensive as their higher SES peers (James et al. 1987).

Interestingly, John Henryism was unrelated to the blood pressure of whites (James et al. 1987). This finding may reflect the different socioeconomic circumstances of these two racial groups, the absence of whites at the extremes of the SES distribution in this study, and/or the differential impact of stress. The available evidence suggests that existence in the lower SES groups may be more stressful for blacks than for whites. For a given level of education blacks receive less income than whites (DHHS 1986), and in employment settings, even after controlling for job experience and education, blacks are more likely than whites to be exposed to occupational hazards and carcinogens (Robinson 1984). Lower SES blacks also experience higher rates of

some stressors (such as unemployment) than lower SES whites and exposure to both poverty and discrimination may be particularly productive of stress (Williams 1990). Other recent experimental evidence indicates that stress may have more adverse effects on African Americans than whites (Light et al. 1987).

Blood pressures are very labile and vary according to an individual's level of activity, emotional state, and stress. It appears that chronic exposure to adverse working and living conditions are a critical determinant of the chronic elevations of blood pressure levels that are common in the African American population. Health behaviors, such as the excessive intake of alcohol, sodium, dietary fat and inadequate physical activity are also determinants of high blood pressure (Williams forthcoming).

Health Behavior

Health behaviors further illustrate how the health problems of black males are embedded in the social, economic, and political structures of society. Health behaviors, such as smoking and alcohol use, appear to be central determinants of health status. The U.S. Surgeon General, for example, has indicated that almost half of U.S. mortality is attributable to unhealthy behavior or lifestyle (U.S. Department of Health, Education and Welfare 1979). In comparison, 20 percent is due to environmental factors, 20 percent to genetic factors, and 10 percent to inadequate medical care. It has been estimated that the health status improvements possible through increases in healthy behaviors exceed those that would be achieved if an overnight cure were found for heart disease or cancer (Olshansky 1985).

Moreover, health behaviors are primary determinants of the heavy burden of disease in the black population. Blacks smoke more than whites and are more likely to abuse alcohol than whites. The recent report on Black and Minority Health identified six causes of death that are responsible for 80 percent of the 60,000 annual excess deaths in the black population (U.S. Department of Health and Human Services [DHHS] 1985). Table 1 indicates that cigarette smoking and/or alcohol abuse is a risk factor for five of the six causes of death. Thus, the two most serious drug problems in the U.S. are cigarettes and alcohol. Last year crack and cocaine were responsible for 5,000 deaths. In contrast, smoking caused 390,000. That is the equivalent of three fully loaded jumbo jets crashing every day and everyone on board dying! Alcohol directly causes 100,000 deaths and plays a role in an additional 100,000. Smoking and alcohol are thus responsible for the largest and most accepted ongoing mass slaughter in the modern world.

Table 1
The Leading Causes of Death for Blacks and Their Associated Fisk Factors

CAUSES OF DEATH	RISK FACTORS
Cardiovascular Disease	Smoking, high blood pressure, elevated serum cholesterol, obesity, diabetes, lack of exercise.
Cancers	Smoking, alcohol, solar radiation, worksite hazards, environmental contaminants, diet, infectious agents.
Homicide, Suicide, and Unintentional Injuries	Alcohol or drug misuse, stress, handgun availability.
Diabetes	Obesity.
Infant Mortality	Low birth weight, maternal smoking, nutrition, stress, trimester of first care, age, marital status.
Cirrhosis of Liver	Alcohol.

Source: DHHS 1985 (Vol. II)

Higher rates of smoking and alcohol abuse among blacks represents a dramatic historic shift in the social distribution of these behaviors. In the 1930s lung cancer death rates for blacks were half that of whites, and up through the 1950s smoking rates for blacks were lower than for whites (Cooper and Simmons 1985). Similarly, if we use death rates for cirrhosis of the liver as an indicator of alcohol use, higher levels of alcohol abuse among blacks than whites are also a relatively recent phenomenon. Up through 1955 age adjusted mortality rates for cirrhosis of the liver were higher for whites than for blacks (DHHS 1985:Vol. VII). Accordingly, efforts to understand and address the health problems of the black population must come to grips with the social structures and processes that facilitate the initiation and maintenance of particular health behaviors.

Most current discussions of health behaviors view them as matters of personal choice. Smoking and alcohol use are treated as if they were autonomous, psychologically oriented factors that are unrelated to working and living conditions and independent of the broader social and political order. John Knowles (1977:58) a former president of the Rockefeller Foundation, typifies this approach with his assertion that we are "born healthy and made sick as a result of personal misbehavior." He argues that individuals are ultimately responsible for their own health and health problems and are under a "moral obligation" to preserve health because one individual's ill-chosen health practices can become another's "shackle in taxes and insurance premiums." Some sociologists have also relied implicitly or explicitly on variants of this psychologically-based "blaming-the-victim" ideology to account for the positive association between health enhancing practices and social status. For example, Mechanic and Cleary (1980:813) indicate that "poor health behavior is part of a lifestyle or orientation reflecting a poor ability to anticipate problems, mobilize to meet them, and cope actively."

In contrast, the evidence clearly indicates that the social distribution of health behavior is dependent on cooperative efforts by the state and powerful economic interests. The very existence of the alcohol and tobacco industries, the price and availability of their products, and thus their profitability are due to specific state action or inaction on their behalf. The financial resources that the alcohol and tobacco industries control have led to a symbiotic relationship with the state and has provided them with the necessary power to coopt other influential actors that would otherwise attempt to mobilize the state to act against them.

The dependence of the state on tobacco and alcohol revenues explains in part why these products are legal in the United States. Tobacco, for example, is exempted by law and administrative decision from the purview of the Consumer Products Safety Commission, the Food and Drug Administration and other federal regulatory agencies (Warner, Ernster, Holbrook, Lewit, Pertschuk, Steinfeld, Tye, and Whelan 1986). If the same standards applied to other products controlled by these agencies were applied to tobacco, it would be banned as a consumer product. Yet although tobacco is harmful when used as intended and remains the nation's most important source of preventable deaths, it escapes federal regulation.

In the case of alcohol, the link between legality and tax revenues is even more transparent. Prohibition (1919-1933) was a success from a public health viewpoint. Alcohol consumption decreased by one-third to one-half, and there was a marked decline in the incidence of cirrhosis of the liver, alcoholic psychoses, and arrests for drunkenness (Burnham

1968; Aaron and Musto 1981). However, prohibition was repealed during the Depression, in part to raise badly needed federal revenues. The federal excise taxes on alcohol remain unchanged until 1951 when they were raised to assist in the financing of the Korean War (Bunce et al. 1981).

Both industries have been very active (and successful) in lobbying against tax increases (Bunce et al. 1981). As a result of this considerable influence exerted over the legislative agenda on tax increases, federal excise taxes on alcoholic beverages and cigarettes (based on a fixed-rate per unit rather than a percentage tax) were not raised since 1951 and 1952, respectively, until the Reagan administration increased them during the recession of the early 1980s [Cowan and Mosher 1985; Fritschler 1989). This falling rate of taxation led to a decline in the real price of tobacco and alcohol beverages. Given that both tobacco and alcohol consumption are very responsive to price increases (Davis 1987; Cook 1983), the government's failure to let taxes keep up with inflation has been an important mechanism not only to keep these products profitable but also to maintain, if not increase, consumption levels.

Tobacco has the highest dollar yield per acre of any crop grown in the U.S. This distinction is due in large part to a price support program operated by the U.S. Department of Agriculture. The marketing and quota rules of this program protect growers from price instability, and keeps the prices of tobacco up by holding the lid on tobacco production. Although some have noted that the actual costs of the program to the government is small, the operation of the program clearly indicates the state's priorities in the contradiction between profit and safety. The Federal government spends four times as much on the administrative expenses of the program than it does on the Office of Smoking and Health, the federal agency dedicated to educating the public on the risks of smoking (Marwick 1984).

There are more retail outlets for alcoholic beverages in black and poor neighborhoods than in more affluent areas (Rabow and Watts 1984). This has not occurred by chance. Government policies control the availability of alcohol. Retail outlets for alcoholic beverages are licensed in every state and there is a positive association between availability and consumption.

Building Alliances. The alcohol and tobacco interests are also able to wield power over legislative agendas because of their ability to build coalitions with potential adversaries. Groups that may have sought government action against these industries are coopted by substantial contributions of monies and assistance from the tobacco and alcohol producers. For example, the alcohol industry provided financial and technical support to Mothers Against Drunk Drivers and Students

Against Drunk Drivers when these organizations were formed (Mosher and Jernigan 1989). In 1987, state legislative associations received a quarter million dollars from tobacco companies, and Phillip Morris and RJR Nabisco provided over $4.3 million to black, Hispanic, labor and women's groups (Levin 1988). These groups included the black, Hispanic, and Women's Congressional caucuses, the National Urban League and the United Negro College Fund. Similarly, during 1985-1986 alcohol industry political action committees donated $1.2 million dollars to key legislative leaders and members of Congress and provided an equivalent amount of financial support to state legislators in California (Mosher and Jernigan 1989). Religious organizations have also received generous contributions from tobacco companies. And the outpouring of gratitude from the religious community serves to enhance the image of the tobacco industry. The National Conference of Christians and Jews, Catholic Charities, the Anti-Defamation League of B'nai B'rith, among others, have all sponsored dinners to pay tribute to tobacco company executives (Blum and Fitzgerald 1985).

The result of these contributions has been a reluctance of these groups to make formal statements against these industries or on the health effects of smoking and alcohol use. Moreover, some companies (such as Adolph Coors Co. which agreed to invest $625 million over five years in black and Hispanic areas) explicitly tie continued economic support to increased consumption of the companies' products (Hacker et al. 1987). These industries do not always win but they have been very successful in derailing hostile legislative action. In Congress during the 1985-1986 year, none of the 160 bills that would have restricted the tobacco industry passed and only one was passed in the following year (Levin 1988).

Social Conditions. The need to use alcohol and tobacco is rooted in social structure. Social and economic deprivation create adverse working and living conditions from which people attempt to escape. That is, tobacco and alcohol are mood-altering agents frequently employed to provide relief from the personal suffering that is induced by large scale social structures. Cigarette smoking and alcohol use are socially approved ways to deal with stressful working and living conditions (Berkman 1982). Both the distribution of stress, in occupational, residential and family environments, and the resources to cope with it vary with social status (Williams and House forthcoming). The disadvantaged face more stressors and have fewer options for dealing with them. There is need for greater recognition that social structures create these stressful living conditions and working environments and shape the nature of the adaptive response of social groups.

Scientific research on the reasons why people smoke indicates that people smoke to reduce as distress, anger, fear, and nervous tension (Benfari, Ockene and McIntyre 1982). Stark (1982) has noted that smoking behavior increases in women when they enter the labor force, and in high school graduates who are unable to find work. Data from a longitudinal study of occupational stress reveal that cigarette smoking increases during periods of high stress (Conway, Ward, Vickers and Rahe 1981). It is also instructive that very high rates of smoking have been noted in stressful institutional situations. Prevalence rates in the military are 47 percent, with even higher rates (80% to 85%) in prison populations (Davis 1987). Cigarette smoking appears to be a potent strategy that can break up the drudgery of people's lives and bring diversion and, at least, temporary relief from the chronic irritations and hassles people face. Blair (1979) explains that given that the nicotine high lasts 20-30 minutes, smoking provides the ideal solution for tedious, boring jobs. They not only help pace out a day -- on the production line, in the typing pool, behind the lunch counter or waiting in a welfare line -- but they give you a steady flow of small rewards to keep on trucking. No wonder, according to the U.S. Department of Agriculture, cigarettes are the first luxury item poor people buy (Blair 1979).

Similarly, alcoholic beverages are used for emotional self-regulation. Feelings of powerlessness and helplessness have been identified as critical determinants of substance abuse (Schinke et al. 1988). Alcoholics routinely indicate that drinking helps them to relax and reduce tension (Horwitz et al. 1987). The relationship between perceptions of control and drinking behavior has been clearly demonstrated in the work of Seeman and his colleagues (Seeman, Seeman and Budros 1988; Seeman and Anderson 1983). In a study of the drinking habits of working and lower-middle-class men, these researchers have demonstrated that an individual's sense of powerlessness is positively related to drinking frequency, drinking quantity, and drinking problems. Moreover, stressful life experiences were positively related to increases in both powerlessness and drinking problems.

Other data reveal that the sale of alcoholic beverages increase during economic recessions and periods of increasing unemployment (Singer 1986). Thus, the social and economic stress created by large scale social processes appear to be a critical determinant of alcohol consumption. It is also instructive to note that since colonial times alcohol has been used as a labor control device (Singer 1986). Alcohol and tobacco use may thus have important **social** consequences beyond their effects on health status. The use of drugs, legal or illegal, to deal with problems may encourage people to suffer rather than resist.

CONCLUSION

McCord and Freeman (1990) in their study of excess mortality in Harlem indicated that poor black communities with extremely high mortality rates should be designated as disaster areas, so that they would be recipients of a major new political and economic commitment to eliminate the underlying socioeconomic causes. I concur. The Bush administration is currently committed to investing billions of dollars to rebuild the economies of Panama and Nicaragua. This is entirely appropriate given our role in creating the current crises those countries face. Similarly, the socioeconomic realities that confront black males were created by large scale economic and political interests. We also need to make a major commitment to improving the economic situation and thus the health status of African Americans.

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Pathways to Violence

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Introduction

Throughout the ages, interpersonal violence has been a characteristic of human beings. Trying to understand the causes and prevention of this behavior remains problematic because violence is a very complex social phenomenon. One definition is from the National Commission of the Causes and Prevention of Violence: "The overtly threatened or application of force which results in injury or destruction" (*Violence in America*, 1983). Another defines violence as an intense, turbulent or furious action, force of feeling or expression, often destructive. These definitions show the broad nature of this behavior. In order to discuss causes or prevention, it is necessary to narrow the scope since violence varies in degrees, and in forms from one group to another.

The complexity of this behavior makes it necessary to specify the particular category of violence being addressed. For example, geneticists look to heredity; psychologists examine the individual; psychiatrists look to pathology and mental illness; and sociologists focus on society's structure. Many conservatives believe more and stricter laws and capital punishment are the answer while many liberals think that the existing laws are unfair and too restrictive, thus increasing the violence rate.

To further complicate the matter, at least two distinctly different kinds of violence have been identified: (1) *Instrumental Violence*, is undertaken as a tool for achieving some other end (e.g. armed robbery and war); and (2) *Expressive Violence* is the acting out of anger, fear or frustration (e.g. jealous rage, hatred, other interpersonal conflicts). Both of these types of violence may manifest in the form of either aggressive of defensive violence. *Aggressive violence* is for the purpose of enjoying gains to which one is not entitled or for destroying or injuring others. *Defensive violence* is to repel an actual or expected attack (Jenkins and Gowdey, 1981).

The specific acts of violence that these definitions referred to include violent human acts such as homicide, forcible rape, aggravated assaults, robbery and suicide. All other types of violence such as political, state, and group violence have are not discussed in this paper.

The purpose of this discussion is to identify early conditions that generally lead to the above acts of violence. In other words, we are attempting to identify "Pathways to Violent Interpersonal Behavior," which will make it possible to retrace these paths backward in order to design intervention strategies for their reduction. These various acts of violence are seen to emerge from unique immediate causes. However, there are common underlying causes that may be examined, such that one intervention strategy may affect several types of violence. To develop this thought, we will follow the social interaction of the hypothetical individual child from childhood to young adulthood, and from his primary to his secondary and tertiary group relations.

This discussion will be from a social psychological viewpoint, where we will examine the environmental (social and physical) and personality factors in the development of the individual to act or react violently. A checklist of behaviors leading to violence is as difficult to specify as one leading to any deviant behavior, since any element listed can appear in different degrees in different children (delinquent or non-delinquent, violent or non-violent). However, researchers are beginning to focus on behaviors that may be underlying causes of violence or precursors to violence which reinforce the observations that violence is a patterned response to internal and external pressures.

At one time or another crime and violence have been explained on the basis of race, climate, political ideology, mental illness, relative deprivation, environment,etc. The problem with these explanations is that each has been promoted as the sole cause of these behaviors. Our view of how violence develops in the individual path to violence is not exhaustive nor will it be a single factor approach.

African-American males are disproportionately represented in violent crimes. Forty-seven (46.8) percent of the violent crimes in this country, and 53.5 percent of the murders were perpetrated by Blacks. The overwhelming majority of the perpetrators are male (Uniform Crime Reports, 1988). The population described herein refers generally to most aggressive persons, and specifically to African-American males because they are at highest risk.

In this discussion, we will examine the influence of two social institutions as well as the community and substance abuse. The two social institutions, where early behaviors (precursors) leading to violence may emanate, are the school and the home.

The Home

Studies on aggression suggest strongly that violence is a learned behavior (Bandura, 1973; Patterson, 1983). The home is one of the places where this behavior can be expected to have been learned. Some researchers see the home as the "cradle of violence" (Steinmetz and Straus, 1981).

The magnitude of violence in the home is suggested by many statistics appearing in the literature on this behavior. For example, in Detroit, 50 percent of all homicides are domestic. It is also of note that a significant number of police calls involve family disputes. Nationally, it is estimated that 1.4 to 1.9 million children are physically abused by family members and 2 million wives are beaten by their husbands. A person is more likely to be assaulted or killed in the home by a family member than anywhere else or anyone else (Gells and Straus, 1979; Uniform Crime Reports, 1988).

In growing up, the child acquires varied knowledge and skills, and feelings of what is right and what is wrong. The child learns the ways of his society from his family. It is generally accepted that the family plays a crucial role in exposing the child to violence or non-violence. If the child sees violence or has violence inflicted upon him, he is much more likely than others to absorb this behavior as being a method of conflict resolution. Therefore, children learn violence not only by observing it in their parent-parent interactions, but also by experiencing it through child abuse and practicing it through sibling aggression. Other conditions in the family associated specifically with the maladjustment of the African-American child include poverty, and racism and their manifestations.

Recently, the father's roles in the family have been shown to play a decisive part in conveying to the child a sense of social order. It is thought by some social scientists that the father's influence on the social climate within which his children's many experiences occur is perhaps the most important (Benson, 1984).

In the family, the father is often the most frequent abuser, especially in cases of physical abuse. This abuse usually involves not only the child, but also other family members. Further, research has shown that this abuse is more frequent when the abuser is a stepfather or a father surrogate (Lynn, 1974; Roberts, 1987). The home environment of the abused child then seems a fertile place for the beginning of the violence cycle, perhaps the first pathway to violence.

Families that are unstable, one-parent, and plagued with violence, inadequate parenting and role models, are at high risk for producing children with behaviors.

Many studies demonstrate the weak influence that families have in molding future goals of high-risk children and that, indeed, they are looking to influences outside the family and school for models of future goals and behaviors. Inadequate parenting, family violence, etc. may produce behavior that may manifest itself in poor self-concept, poor interpersonal skills, self-destructive values and actions, which, in turn, may result in running away, substance abuse, deviant behaviors, and violent behavior.

The School

More and more, the school has taken on the responsibility of socializing the child into the ways of his culture. Evidence has shown that the school has not dealt grappled adequately with the African-American child. This child has been taught values that do not enable him to achieve in school or in later life. For example, the schools, since integration, have not prepared the African-American child for survival in a racist society. The formal education that the African-American child receives in the nation's public school system is designed for the majority child's survival. Since 1954, this system has not admitted or recognized in its teaching that the African-American child is viewed differently not only by most of his teachers but also by most of the world that he will subsequently attempt to function in. The school's curriculum has failed to respond to differences among African-American the small middle class and the very large lower class families, although it is known that socioeconomic levels affect a child's degree of success in school. Further, research has shown that the degree to which a child succeeds or fails in school is a function of maturation.

Maturation as a determinant of intellectual achievement encompasses these factors: (1) the degree to which a child values competent performance in a given area; (2) the child's expectation of success or failure; (3) the minimal level of achievement with which the child can be satisfied; and (4) the extent to which the child sees himself or others as responsible for his success or failure This maturation and expectation is further affected by the child's observation of his parents' employment success, whether educated or not (McAdoo, 1988).

The school socialization for the African-American child may actually conflict with the parents' or family's socialization, i.e., where the family is socializing the child for survival, and the school is socializing for success in a culture that will systematically deny the child the access to that success.

Despite our knowledge about the harm done to children, the African-American child still learns mostly about white society in the school room. Also, he comes to perceive that he is not wanted in the school room or in the white world, and that he is considered inferior and bad. At most, the schools can instill values in the African-American child that inadequately prepare him for the world he must live in. But, most likely, it will create an ambivalence that will alienate him from the school, and he will turn to his peers for acceptance, drop out of school and begin the life-long trek through the various manifestations of this decision, one of the manifestations may be violence.

Remedies for this condition in the schools have been proposed by many authorities; however, to date, these remedies have been thwarted by political considerations, such as having a majority of white teachers in majority African-American schools, then blaming the child for the failures evidenced. Hiring of African-American teachers now may have some effect on Preventing these failures. However, many of the recently-graduated African-American teachers are those who have successfully adapted to the values of white America and could possibly inflict the same (or worse) effect as their white counterparts.

Since the socialization process of the high-risk African-American family may be impaired, the school is a powerful socializer of today's African-American child. The school is thought to be a reflection of the existing social order despite the fact that its function is to produce individuals who can function successfully in society. If this institution is also faulty, the damage to the child is enhanced.

Like the home, the school can be for many young people, a place where violence is an observed practice, learned, and hence, normative in conflict resolution. Other factors that promote behaviors that are early precursors to violence are school failures, poor interpersonal skills and poor self-image.

The Community

There is strong evidence to suggest that there is a vast amount of socialization taking place outside the formal institutions such as the home, school and church. The individual whose family ties are weak or non-existent finds peers, role models, significant others, etc. outside of those institutions to emulate. This seems to be especially significant among African-American males, where violence is escalating and often results in homicide. In a study conducted by this author of 500 black males in Nashville, Tennessee (Dennis, 1980), the majority of the victims and perpetrators of homicide reported that they did not have a father or father surrogate in their childhood.

Most victims and perpetrators of violence in this sample were men who were born to single parents, and/or teenage mothers. They reportedly participated minimally in family activities while spending much of their time "in the streets" with peers or in juvenile detention institutions. This obvious minimal participation with family suggests that much of their socialization took place outside the family, possibly by peers, role models and others.

Very little is being done to develop most high-risk communities where the African-American child can be in an environment where positive socialization can occur, where he can learn survival skills, observe successful role models, develop a positive self-concept, a sense of hope, and independence. All present attempts are woefully inadequate because they reach small numbers of children, have low impact on their overall behavior, and are either carried out by voluntary organizations or they are inadequately funded.

In studying such programs in Nashville, Tennessee, we found that individuals, groups, local and state agencies in these neighborhoods not only had no contact with each other, but sometimes were not aware of each other, even though they were working with the same population. Overlaps and gaps in program efforts were found; program effectiveness or evaluations were non-existent. This state of affairs is probably evident in other communities trying to improve the well-being of African-American children. It is agreed that efforts to develop communities where positive socialization is maximized is of utmost importance for African-American children whose present family life may be impaired and whose school experience may be damaging.

There is no doubt then that the community also serves as a place of socialization. If it is a good community in terms of child exposure, the positive outcomes for successful living are enhanced. However, children in communities or neighborhoods which expose them to negative experiences will be at high risk for learning violence as a normative way to reach desired goals and resolve conflicts. Minimizing violent role models while increasing positive role models is one way of socializing children for success and minimizing violence.

For African-Americans, discrimination has created despair and a lack of hope which have created, in turn, conditions where violence has been a natural outcome--probably initiated early on mostly by stressful social conditions, and, later, by a tradition of violence. This is to say, the frustration and stress of blocked goals may have initiated ghetto violence (the frustration aggression theory) (Dollard, 1939). This condition has existed long enough so that the child learns violence by observing and participating in violent quarrels and brawls in the unintegrated community of the ghetto (the social learning theory). Some researchers refer to this "place" as a subculture or microsystem (Bandura, 1979).

Further, the children in these communities view television, where violence is a constant dramatic theme and an integral part of cartoons, at a higher percent than most other children (Elkin and Handel, 1984). These television programs teach children a variety of violent techniques for coping with their frustrating and hostile environment. Violence, then, is seen as an adaptive mechanism.

The pressures and frustrations that the child is exposed to in ghettos, as well as alternatives for relief including the availability of guns, make the ghetto an ideal "place" to teach violence to a high percentage of each generation that passes through it. It is generally recognized that, as violence increases in a community, the tolerance for its occurrence also increases. Violence in these communities seems to be just one of the alternatives to conflict resolution. Substance abuse may be another.

Alcohol and other Substance Abuse

Researchers have linked alcohol abuse to violence for many years now. In some cases, alcohol abuse is seen as the cause of violence; in other cases, it seems to intensify violence. Alcohol abuse has manifested violence in the family as well as in interpersonal relationships outside the family (McBride, 1981). African-American males demonstrate this in the high rate of reported substance abuse and in homicide. The many types of alcohol abusers and the varied forms this abuse takes is also noted in the vast amount of literature on the subject.

The prevalence of this problem in the population of African-American males is unacceptably high. It is estimated that 20 percent of this group have a problem with alcohol. In a recent study, (Dennis, 1980), we found that more than half of our population of African-American males were frequent (more than once per week) users of alcohol, and over 90 percent were occasional users. It is also known that, in the majority (up to 80 percent) of violent incidents, the perpetrator and/or the victim were using alcohol (McBride, 1986), and that the moderate or heavy drinker is more likely to be the aggressor in violent encounters than the light drinkers or abstainers.

Alcohol abuse and violence are diseases that overlap in that some of the forces associated with alcohol abuse are also associated with violence. In fact, some researchers note that neither appears to be the cause of the other, but appears to be learned from the same sources. The *synergistic* relationship between alcoholism and violence is further noted through their many common characteristics. They fulfill many common needs and complement each other, especially in the case of family violence.

The tolerance levels for alcoholism and violence have increased to where they have become normative or expected behaviors. These behaviors are learned at home or in the broader community (Chavez, 1989). Alcoholism and violence are used to resolve conflicts or problems such as poverty, economic, depression, blocked goals, forced reactions, sexual mastery, control, jealously, possessiveness, etc. Indeed, society in general has tolerated both violence and alcoholism especially in their less extreme form.

The victims of alcohol and violence participate in their victimization in various normative ways, which seem to maintain or prolong and enhance these behaviors until they become so extreme that they terminate in institutionalization or in death (Dennis, 1985).

Abuse of other Substances and Violence

In the past ten to twelve years, and especially in the 1980s, we have seen a dramatic change in terms of "drug of choice" substance abuse. Since the late 1970s, crack cocaine has been highly utilized. Some of these abusers also used marijuana and alcohol simultaneously. There is a difference in the abuse and in the violence that was manifested by these "new" types of substance abusers.

While the research on specific violent behaviors is still underway, observations of these occurrences suggest that recent homicide and aggravated assaults are more related to drug conflicts than to interpersonal conflicts, as was observed in the early decades of this century when alcohol was the drug of choice in substance abuse.

Wolfgang noted in the 1960s and 1970s that the violence manifested by black males who were alcohol abusers was more interpersonal and victim precipitated, e.g. fights over money, women or non-respect; and even a form of self-destructive behavior (Wolfgang, 1982). Today, the violence, especially homicide, is overwhelmingly drug-related, e.g. drug users' non-payment of drug debt, violent attempts to obtain money for drugs that end in homicide. Also, the age of the victim of violence as well as that of the perpetrator has been lowered to the late teens and early twenties. This change in drug of choice with its resultant violent behavior as well as the lowering in age has its own set of ramifications, which need to be explained and addressed if intervention programs are to be designed for its reduction.

Discussion

Many reasons have been given to account for violence. We have examined the literature to identify some of the social characteristics of those who have been perpetrators of violent behaviors. We found that the violent perpetrators were characterized by the following:

1. low education (less than high school)
2. unemployed

3. substance abuser
4. trouble with the police
5. family and/or community violence
6. large family (5+ siblings)
7. no best friends
8. emotionally unstable
9. discontent
10. verbally inarticulate
11. experienced and/or perceived inequality
12. carried a weapon
13. low self-esteem

This list is not exhaustive nor did any violent person necessarily have all of the above characteristics. However, it is noted that most of the perpetrators had several of these characteristics. Our task then was to look at experiences in development that may have brought these men to this point.

In programs being conducted by the Nashville Urban League, Inc. and the Bethlehem Center of the United Methodist Church to prevent homicidal violence, it is the task of this writer to identify childhood behaviors that may indicate or predict violent behavior, either at present or later on in their lives. The male children in the programs are from nine to 16 years old.

Preliminary results show that programs such as those of the Bethlehem Center and Urban League, Inc. are beginning to affect the behaviors (precursors) under study, e.g. school attendance, grades, fighting goals and self-concept. So far, there is a marked difference between children in these programs and their controls. The programs demonstrate that it is possible to help children in high-risk communities to redirect or minimize behaviors that may evolve into violence by reducing frustrations and offering alternative solutions for problem-solving and interpersonal conflicts, providing positive role models and helping to establish future goals.

Summary and Conclusion

It is widely held that the violent home environment and the ghetto-like African-American communities are places where the pathways to violence, or cycles of violence, are created and maintained. Interrupting these cycles are as complex as their sources. For family violence, it is clear that the cycle of violence should be interrupted in the child's family of origin in order to achieve the highest level of success. Minimizing or reducing the child's experiences and observations of violence is another method of interrupting the violence cycle.

Various means have been established to treat and prevent child abuse. That is, experts all generally concluded that the long-term solution must involve changing the structure of the society which produces places where violence occurs. To do this, attention must be given to raising the educational level, increasing employment and changing the (norm) normative methods of responding to interpersonal conflicts.

Why is violence more prevalent among African-Americans? Violence in this group has existed in various forms since slavery. First, violence was inflicted on this group by others. Today, violence is inflicted upon this group by others as well as by themselves in a long-term tradition of using violence as one means of conflict resolution, violence as a reaction to frustration, and violence as modeling and rewards.

The main hope for reducing the level of violence in a society to a tolerable level, according to Frank (1971), lies in reducing its psychological and socioeconomic instigators and creating more effective institutions for its control. Heretofore, the institutions that have been the most concerned with this behavior have been those in the criminal justice system. We know now that other social institutions in the society must join the criminal justice system to assist in reducing this cycle of violence.

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