

# Advancing the Africentric Paradigm Shift Discourse: Building toward Evidence-Based Africentric Interventions in Social Work Practice with African Americans

*Dorie J. Gilbert, Aminifu R. Harvey, and Faye Z. Belgrave*

For over a decade, a number of social work scholars have advocated for an Africentric paradigm shift in social work practice with African Americans; yet the paradigm shift has been slow in coming with respect to infusing Africentric theory and interventions into social work practice, education, and research. Interventions that infuse Africentric values (such as interdependence, collectivism, transformation, and spirituality) have been shown to create significant change across a number of areas important to social work practice with African Americans. However, a barrier to the full integration of Africentric models into social work practice is that Africentric programs lack cohesive documentation and replication and, thus, have limited potential to be established as evidence-based practices. The authors present an overview of various Africentric interventions, including their program components and methods of evaluation, with the aim of establishing guideposts or next steps in developing a discourse on Africentric interventions that are promising best practices or are emerging as evidence-based practices. The authors conclude with implications for social work practice, education, and research and a call for Africentric scholars to engage in increased discussion, dissemination of manualized treatments, and collaborative research to build the evidence-based Africentric knowledge base and foster replication of studies.

KEY WORDS: *African Americans; Africentric; best practices; culturally relevant interventions; evidence based*

Social work practice with African Americans has evolved from a generalist perspective that tended to overlook cultural values to one that recognizes the need to incorporate cultural sensitivity and cultural competence. In particular, the strengths perspective (Hill, 1971, 1999; Saleebey, 1992), empowerment theory (DuBois & Miley, 1996; Solomon, 1976), and the person-in-environment framework (Germain, 1991) have supported the profession's move toward ethnic-centered interventions, which at minimum should emphasize the cultural competencies of the practitioners and attention to salient ethnocultural factors, such as beliefs, language, and traditions. Beyond recognizing strengths and cultural sensitivity, the Africentric paradigm is a complementary, holistic perspective that emerged as a response to traditional theoretical approaches that failed to consider the worldviews of historically oppressed populations. Africentric approaches address the totality of African Americans' worldview

and existence, including their experiences of collective disenfranchisement and historical trauma as a result of slavery and persistent racial disparities. Interchangeably referred to as "Afrocentric," "Africentric," or "African-centered," interventions are based on the principle of reinstilling traditional African and African American cultural values in people of African descent. This approach stems from the premise that African Americans, for the most part, survived historically because of values such as interdependence, collectivism, transformation, and spirituality that can be traced to African principles for living (Akbar, 1984; Asante, 1988; Karenga, 1996; Nobles & Goddard, 1993). Over a decade ago, Schiele (1996, 1997), Harvey (1985, 1997), and Harvey and Rauch (1997) began to develop and advocate for Africentrism as an emerging paradigm for social work practice. Indeed, a number of social work scholars have weighed in on the discourse, calling for a much-needed Africentric paradigm



shift in social work practice with African Americans (Carlton-LaNey, 1999; Daly, Jennings, Beckett, & Leashore, 1995; Daniels, 2001; Freeman & Logan, 2004; Gibson & McRoy, 2004; Manning, Cornelius, & Okundaye, 2004; A. Roberts, Jackson, & Carlton-LaNey, 2000; Sherr, 2006; Swigonski, 1996; White, 2004). Harvey (2003) provided a general guide for a social work shift away from Western approaches to social work conceptualizations and practices with African Americans via an Africentric paradigm. Yet the paradigm shift has been slow in coming with respect to infusing Africentric theory and constructs into social work practice, education, and research.

Furthermore, although *evidence-based practices* (EBPs), those counseling and prevention programs that have the best-researched evidence, have become the "gold standard" for practice and research, there is a growing recognition that EBPs do not automatically translate intact across cultural lines (Bernal & Scharron-del-Rio, 2001; Davis, 1997). In fact, few EBPs are culturally congruent for African Americans. Conversely, Africentric interventions are culturally congruent practices specifically for African American populations and have demonstrated significant positive outcomes across several areas important to social work practice with African Americans, including increases in positive child, adolescent, and family development (Belgrave, 2002; Belgrave, Townsend, Cherry, & Cunningham, 1997; Constantine, Alleyne, & Wallace, 2006; Dixon, Schoonmaker, & Philliber, 2000; Harvey & Hill, 2004; Thomas, Townsend, & Belgrave, 2003; Washington, Johnson, Jones, & Langa, 2007). Other Africentric interventions have shown improved outcomes for incarcerated individuals and decreases in substance abuse and HIV risk behavior (Gant, 2003, 2007; Gilbert & Goddard, 2007; Harvey, 1997; Longshore & Grills, 2000; Nobles & Goddard, 1993). Although many Africentric programs show great promise, they lack the replications needed to become recognized as EBPs, and so most are considered *emerging best practices*—interventions that are promising but less documented and replicated than EBPs. This article begins to address the gap between evidence-based and culturally congruent Africentric interventions for African Americans.

Following a discussion of contemporary psychosocial concerns of African Americans and the relevance of Africentric interventions, we present a case for greater documentation and dissemination of the current emerging Africentric best practices

to accelerate the infusion of Africentric-based interventions into social work practice. Based on our larger, ongoing project to establish a collective volume on Africentric best practices, this article presents a selected sample of emerging Africentric best practices in two categories—child, adolescent, and family development and substance abuse and HIV prevention—and discusses implications for social work practice, education, and research.

## BACKGROUND ON AFRICAN AMERICANS' PSYCHOSOCIAL CONCERNS

African Americans make up approximately 13 percent of the U.S. population (U.S. Census Bureau, 2004), and although the term "African American" may accurately reflect those individuals who are descended from slaves in this country, the more than 33 million individuals comprising various black ethnic subgroups (for example, Caribbean, Central and South American, and African immigrants) underscore the diversity of this population. The present discussion primarily addresses U.S.-born African Americans who have experienced deculturalization through historical trauma, starting with capture from Africa to the ongoing inequities in the United States.

Historical strengths of the African American family include a strong achievement orientation and work ethic, flexible family roles, strong kinship bonds, and a strong religious orientation (Hill, 1971). Today, African Americans continue to build on traditional strengths of kinship and spirituality (Hill, 1999), yet subgroups of African Americans experience serious negative outcomes and disparities. Although somewhere between a quarter and a half of today's African American families are considered middle class, African Americans continue to experience serious disparities in education, earnings, and employment compared with white Americans (Attewell, Lavin, Thurston, & Levey, 2004).

Many current health and mental health problems of black Americans can be traced to historical trauma resulting from slavery and persistent societal oppression (DeGruy-Leary, 2005). Historical and current racism underlie current barriers to healthy living for African Americans (Myers, 1988; Nobles & Goddard, 1993). Twenty-one percent of African Americans have reported no usual source of medical care and generally use clinic or emergency room care. Even with differences in income, insurance status, and medical need accounted for, race and ethnicity



significantly affect access to and quality of health care for African Americans (Smedley, Adrienne, & Alan, 2002). The Office of Minority Health and Health Disparities (OMHHD) (2002) reported the death rate for African Americans as higher than that for non-Hispanic white Americans for heart diseases, stroke, cancer, chronic lower respiratory diseases, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

From an Africentric perspective, the etiology of negative outcomes for African Americans lies in individual and structural barriers (for example, discrimination, institutionalized racism). When individuals lack cultural knowledge, self-appreciation, and positive racial identification but internalize negative views, myths, and stereotypes, they become engaged in a constellation of coping responses that are not self-enhancing. These include fatalism, overemphasis on materialism, and self-destructive behaviors—such as substance abuse, violence, and other risk behaviors—in addition to stress and depression (Myers, 1988; Nobles & Goddard, 1993).

Depression among African American women is almost 50 percent higher than it is among white American women; and suicide among African American youths between the ages of 10 and 14 rose 233 percent from 1980 to 1995, compared with a 120 percent rise for their white counterparts (OMHHD, 2002). Overall, African Americans account for approximately 25 percent of the mental health needs in this country, but only about 2 percent of the nation's trained mental health counselors are black (OMHHD, 2002), highlighting the urgent need to document and increase culturally relevant interventions and to establish collective work on emerging Africentric best practices, particularly interventions for resource-poor and marginalized African Americans.

#### **AFRICENTRIC INTERVENTIONS: RATIONALE AND LITERATURE REVIEW**

Africentric programs emerged as a response to traditional Eurocentric theories and psychological approaches that fail to consider the worldviews of historically oppressed populations (Akbar, 1984; Asante, 1988). From an Africentric perspective, psychosocial issues confronting African Americans are caused by historical oppression and distress and coping patterns in reaction to the oppression. The group's resilience rests on the development of an identification and acceptance of a culture based on

knowledge of its African heritage and the promotion of behaviors, thoughts, and emotions that foster the liberation of African people from oppression and repression. In short, the reclamation of African culture is key to the survival and positive existence of people of African descent and is a healing phenomenon (Hilliard, 1997; Nobles & Goddard, 1993). One value system (set of guiding principles) for African Americans that can assist them in addressing the root cause of social problems in the African American community is the *Nguzo Saba*: the seven principles representing "the minimum set of values African Americans need to rescue and reconstruct their lives in their own image and interest and build and sustain an Afrocentric family, community and culture" (Karenga, 1996, p. 543). These seven principles are *unity* (striving for unity in family, community, and race); *self-determination* (defining, naming, and creating for oneself); *collective work and responsibility* (building and maintaining community and solving problems together); *cooperative economics* (building and maintaining the economic base of the community); *purpose* (restoring people to their original traditional greatness); *creativity* (enhancing the beauty and benefits of self and community); and *faith* (belief in the righteousness of the black struggle).

Another value system for guiding the life and behavior of African Americans is rooted in the principles of *Maat*, a philosophical, spiritual, and cultural system that reflects principles for living "to support and facilitate the full expression of one's spiritual essence (sense of self)" (Parham, 2002, p. 41). The basic principles of *Maat* are translated through the *Nguzo Saba*, and together these principles assist individuals, families, and communities in obtaining wisdom about self in connection to the spiritual and material realms of being (Graham, 2005). Although African Americans are diverse and vary in the extent to which they endorse these principles, when these values are infused into Africentric interventions, they form the cornerstone of behavior change and empower communities in reaffirming purpose and meaning in life (Graham, 2005).

Chipungu et al. (2000) reviewed Africentric drug prevention interventions and identified three critical components of Africentric programs: (1) components implemented to instill Africentric values such as communalism and spirituality, which increase resiliency and other protective factors while decreasing or mediating risk factors; (2)



components that emphasize the current conditions of African Americans to help reduce societal pressures and build positive African American ideals; and (3) components that include Africentric activities and projects to increase positive sense of self through African and African American historical examples. A number of different programs across the country include these components, yet there is no cohesive documentation of the various programs to determine whether and how they have been evaluated; and overall, we lack knowledge about the additional research and duplication required to advance the discourse on the needed Africentric paradigm shift. Schiele (2000) emphasized the need to evaluate Africentric programs and to replicate Africentric studies. By doing so, Africentric scholars will move closer to establishing criteria for EBP. The best available and most appropriate research evidence is usually ranked hierarchically according to its scientific strength and tends to fall into four levels of evidence (A. R. Roberts, Yeager, & Regehr, 2006; Thyer, 2006):

- *Level 1: Meta-Analyses and systemic reviews:* Meta-analyses present aggregate results across separate outcome studies using different outcome measures, and they typically include only randomized controlled trials (RCTs); alternatively, systemic reviews include quasi- and pre-experimental outcome studies and correlational, single-subject, and case studies.
- *Level 2: Individual and multisite RCTs:* Individual RCTs involve large numbers of clients randomly assigned to treatment and control groups. Multisite RCTs use several independent research teams in varying locations among diverse populations.
- *Level 3: Uncontrolled clinical trials or quasi-experimental clinical trials:* Uncontrolled clinical trials involve assessing many clients one or more times before an intervention, using identical pretest and posttest methods. Quasi-experimental clinical trials add comparison of differing treatment conditions to pretest and posttest procedures.
- *Level 4: Anecdotal case reports, correlations studies, descriptive reports, case studies, and single-subject designs:* These provide the lowest levels of research evidence yet are relevant for specific studies.

The eight Africentric programs chosen for discussion in this article adhere to this spectrum of EBP, and levels of evidence are indicated for each. With the goal of building increased evidence for Africentric interventions along this spectrum, we consider this a first step in identifying and documenting various Africentric interventions to advance, in Proctor and Rosen's (2006) words, the "packaging and communicating [of] this information for better retrieval and application by practitioners" (p. 101).

## **AFRICENTRIC INTERVENTIONS: DEFINITION AND DISCUSSION**

As part of a larger project to document an extensive collection of Africentric programs and evaluation studies, we performed a systematic review of interventions that are grounded in Africentric principles across social work, psychology, and affiliated professional disciplines over the past decade. Intervention programs for review were identified through five methods: (1) computer searches of over 15 different electronic databases (for example, Social Sciences Citation Index, Science Citation Index Expanded, Social Work Abstracts, Sociological Abstracts, Info Trac Web, PsycINFO, Medline); (2) manual searches for studies reported from 1997 through 2007 in major journals and journals focusing on African American issues; (3) examination of the bibliographies of selected articles; (4) Web site searches across a number of the National Institutes of Health, including the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute of Child Health and Human Development; and (5) contact with individual Africentric scholars and institutions.

In defining "Africentric," we included programs with reported findings that specifically included the following: Africentric methods in the description of the program; discussion of Africentric principles such as spirituality, collectivism, and transformation in the description of the background or conceptual framework of the study; infusion of Africentric practices (for example, unity circles, rituals, Nguzo Saba, Maat, African proverbs) in delivery of the intervention; and (4) intervention components addressing African Americans, Africans, or both within the context of their historical and current oppression. The results revealed a myriad of Africentric programs, ranging from small, community-based programs with and without major funding to large-scale, multisite RCTs.



For the purposes of this discussion, we chose eight programs as a representative sample of interventions to highlight in terms of their objectives, outcomes, and methods of evaluation. The programs fall into two basic categories: (1) child, adolescent, and family development and (2) substance abuse and HIV prevention. The following overview is in no way exhaustive, but it provides a snapshot of the current state of Africentric interventions to identify next steps in developing guideposts for best practices that would significantly advance the field toward evidence-based Africentric interventions. The intent of this discussion is not to endorse the broad-scale adoption of EBP, which has both merit and limitations; instead, we are primarily interested in disseminating knowledge and building opportunities for replication of studies and programs—which, naturally, will lead to best practices and EBPs.

### **Child, Adolescent, and Family Development**

Structural racism, poverty, high rates of violence in the community, and poor racial and ethnic identity are some risk factors that work against positive well-being among African American youths. However, strong racial and ethnic identity and Africentric values among children and adolescents have been shown to be positively correlated with healthy development in several studies. We highlight five programs that support these identities and values.

**The NTU Project (Quasi-experimental, Level 3).** Cherry et al. (1998) enlisted African American fifth- and sixth-graders in an Africentric-based program designed to decrease risk factors and increase protective factors for substance use. *Ntu* is a Bantu word that means “essence of life.” Intervention components for fifth-graders included an Africentric education program, a substance use education program, a rites of passage program, a family therapy program, and a parenting program; sixth-graders completed a booster program designed to reinforce skills. Findings supported significant effects for protective factors, particularly knowledge of African culture, increased racial identity, improved self-esteem, and improved school behaviors for intervention but not comparison participants.

**A Journey Toward Womanhood (Quasi-experimental, Level 3).** This is an intensive and comprehensive program designed for girls of African descent ages 12 to 17 (Dixon et al., 2000). Rooted in the African “rites of passage” tradition, the program aims to instill knowledge of cultural roots and

community awareness. The goals are to build and maintain healthy self-esteem; instill cultural pride and self-appreciation; teach life and social skills for self-sufficiency; and discourage teenage pregnancy, juvenile delinquency, school dropout, and drug abuse. The program has been evaluated over a 10-year period, and findings include the following: Rates of sexual activity were significantly higher among program nonparticipants (70 percent) than participants (27 percent); program participants were less likely to get pregnant as teenagers than nonparticipants; program participants were significantly more likely than nonparticipants to demonstrate positive behaviors and endorse the importance of heritage and ethnic pride; and (4) program participants missed fewer school days.

**Sisters of Nia. (Quasi-experimental, Level 3).** Sisters of Nia is a cultural intervention for African American girls in early adolescence, aiming to increase cultural values and beliefs, such as ethnic identity, and positive gender roles and relationships (Belgrave et al., 2004). The curriculum includes 14 sessions led by a female African American facilitator. Some of the session topics are African culture, relationships, appearance, media messages, African American women in leadership, and faith. The Principles of Nguzo Saba and African proverbs are used along with relational and Africentric methods. Intervention group participants demonstrated significant increases in ethnic identity, marginally significant gains in androgynous gender roles, and decreases in relational aggression in comparison with participants who were not in the intervention group. Findings suggest that pre-early adolescence may be an opportune period for implementing prosocial, cultural interventions for girls, particularly to promote resiliency factors. This study replicated previous results showing increased resilience among girls in an intervention group (Belgrave, Chase-Vaughn, Gray, Dixon-Addison, & Cherry, 2000).

**MAAT Africentric Adolescent and Family Rites of Passage Program (Quasi-experimental, Level 3).** Harvey and Hill (2004) implemented the Africentric Adolescent and Family Rites of Passage Program at the MAAT Center for Human and Organizational Enhancement in Washington, DC. The project targeted African American adolescents between the ages of 11.5 and 13.5 years and their families. The program aims to reduce substance abuse and antisocial behaviors and attitudes. The



program's Africentric, strengths-based, family-centered approach is based on the ancient Egyptian principle of Maat. Components included an after-school program, activities to promote family enhancement and empowerment, and individual family counseling, all emphasizing African and African American culture. Findings from a three-year evaluation of the program demonstrated significant gains in participating adolescents' self-esteem and knowledge about substance abuse. Among parents, sizeable but nonsignificant gains were made in parenting skills, racial identity, and community involvement. Additional evidence from focus groups suggests that the program's family-oriented, Africentric approach was advantageous for at-risk youths and that indigenous staff may have contributed to positive outcomes.

***Kuumba Group (Uncontrolled, Pre-Post, Level 3).***

The Kuumba Group was piloted as a therapeutic, recreational group intervention with an emphasis on Afrocentric values, providing mentoring for male African Americans between the age of 9 and 17 (Washington et al., 2007). The purpose of the project was to prevent youths from being placed in foster care. The central strategy was to infuse Nguzo Saba themes into discussions and interactions as an inoculation to counteract the values associated with self-destructive behaviors and stereotypical media images. Implemented with individually and family-focused traditional child welfare and clinical services, curriculum components used previously tested comprehensive rites of passage program activities to affect cultural identity, self-exploration, value clarifications, and nonviolent conflict resolution. Postintervention interviews with relative caregivers indicated slight increases in participants' spiritual orientation and improved school and home behavior among youths.

**Substance Abuse and HIV Prevention**

Substance abuse among African Americans has been linked to hopelessness, deterioration of communities, and self-destructive behavior associated with responses to oppressive conditions. The epidemic of substance abuse has existed in tandem with that of HIV infection, and although African Americans make up only 13 percent of the U.S. population, they accounted for over 50 percent of HIV and AIDS cases in 2003 (OMHHD, 2002). Africentric interventions to prevent and reduce substance abuse and HIV incidence include elements to help

individuals counter oppressive conditions, maintain values congruent with healthy cultural identity, and participate in culturally congruent rituals.

***The Culturally Congruent African-Centered Treatment Engagement Project (Quasi-Experimental, Level 3).*** This culturally congruent intervention applies Africentric concepts in single-session counseling with African American drug users (Grills, 2003; Longshore & Grills, 2000). The intervention method involves the client, the counselor, and a former drug user (peer) viewing a video about drug use together and discussing the topics together as a means of recovery; a dyadic counseling session follows, led by the counselor and joined by the peer, —to bolster recovery-related motivation. Integral to the content and format of the intervention are African and African American values—including spiritualism, interdependence, and transformative behavior based on the principles of Maat—and sociopolitical consciousness raising, in which drug abuse treatment and recovery is reframed as healing the African American community. The project evaluation determined that participants in the motivational Africentric intervention experience were significantly less likely to be using drugs one year later. Findings suggest that culturally congruent values partnered with motivational interviewing techniques may help to advance participants through the transtheoretical stage-of-change process and promote overall recovery.

***Healer Women Fighting Disease (Quasi-experimental, Level 3).*** This is an integrated HIV and substance abuse prevention program targeting African American women (Gilbert & Goddard, 2007; Nobles, Goddard & Gilbert, in press). Rooted in the African-centered behavioral change model, program components emphasize infusion of traditional African and African American cultural values based on the Nguzo Saba and Maat to address women's self-worth and sense of control of life; reinstall traditional cultural values to transform thoughts, feelings, and behavior; and help women develop protective factors that make them less likely to engage in risk-taking behaviors. Sixteen weekly two-hour sessions are delivered by African American facilitators in a community setting; components include behavioral skills practice, group discussions, role playing, and viewing of a prevention video. Findings show significant changes from pretest to posttest in increasing motivation and decreasing depression (cultural realignment), increasing HIV/AIDS knowledge and



self-worth (cognitive restructuring), and adopting less risky sexual practices (character development) for intervention participants relative to the comparison group. Outcomes suggest that integration of an African-centered approach demonstrates promise as a critical component in health promotion interventions for African Americans.

**The JEMADARI Program (RCT, Level 2).** This program is based on a Swahili word meaning "wise companion," which serves as a symbol of positive masculinity. The program is a culturally congruent, RCT intervention for African American men ages 18 to 63 residing in residential treatment programs. The program targets participants' drug and sexual risk-related behaviors (Gant, 2003). The intervention content is based on elements of the Nguzo Saba and includes vignettes and case studies taken from the works of contemporary and classic African American male writers and artists, literature on African American male sexuality, discussions of conditions of African American life (for example, slavery, economic hardship, social discrimination, social inequality, political disenfranchisement, racism), and themes of African American life (for example, political activity; achievement for self and family, race, and society; self-integrity; creativity; struggle). In a six-month follow-up evaluation, investigators assessed adaptive copings skills, perceptions of personal control, satisfaction with life direction, ethnic identity, and adaptive peer group support. In the preliminary findings, JEMADARI program participants demonstrated drug abstinence, condom use, and reduction of sexual partners beyond levels achieved in the standard residential treatment program; the final analysis indicated a statistically significant decrease in number of sexual partners in the past three months from pretest to posttest for the JEMADARI group as compared with the control group (Gant, 2007).

### **SOCIAL WORK IMPLICATIONS**

The general findings for the sample programs presented here support the efficacy of infusing Africentric values and an African-centered approach in programs that target the healthy development of African American children and adults. The hierarchical range of these studies indicates that Africentric research is moving beyond anecdotal and descriptive cases and replication of existing interventions showing efficacy would build a strong case for evidence-based Africentric practice. Al-

though nonrandomized studies can provide relevant empirical support, whenever possible, Africentric interventions should involve randomized selection of treatment and control groups, building toward at least two RCTs conducted by different research teams. To advance the replication of studies across different research teams, researchers must produce and disseminate treatment manuals with clear and detailed descriptions of the intervention components. For example, of the programs discussed here, the recently manualized Sisters of Nia and Healer Women Fighting Disease interventions can now be replicated by other teams of researchers. Finally, researchers should work toward increasing peer-reviewed publication of results across multiple teams of researchers, which will build the knowledge base for Africentric EBP.

A number of implications can be drawn from the discussion, centering on the intersection of education, practice, and research—specifically implications related to the profession's slowness in incorporating Africentric teaching and research. Over the past decade, there have been a number of appeals to social work to take a lead in addressing the inequities and social conditions that afflict many African Americans. Allen-Meares and Burman (1995) described the lack of social work leadership in this area as a "discomforting silence from the social work community" (p. 271). Social workers are on the frontlines of working with clients who experience social, mental health, and health disparities, and they are in the best position to create better awareness and advocacy at local, state, and national levels.

Further discussion of Africentric approaches to working with African American children, adults, families, and community groups is warranted given the significant disparities in areas where social work is highly engaged. Schools of social work are held accountable for developing comprehensive curriculums that prepare students to deliver social services effectively within a complex society. Greater infusion of Africentric theory and research fits with the NASW (2000) *Code of Ethics* on acquisition of cultural competence as an ethical standard and with the Council on Social Work Education's mandate to teaching cultural competency. Awareness of and knowledge about Africentric interventions should be well integrated into professional schools of social work, as are other models of practice. Schiele (1997) noted that "Afrocentric knowledge should not be marginalized or relegated to discrete, elective, or



required courses but rather infused throughout all areas of social work curricula" (p. 816). Advancing these ideas within the social work academic and research setting will require continued focus on engaging social work education and practice professionals.

One major barrier to full integration of an Africentric paradigm into social work curriculums and practice is that Africentric programs lack cohesive documentation, which limits their chances of being established as best practices or EBPs through replication and multiple trials. At the same time, we know that culturally relevant interventions are more likely to lead to enduring behavior change than are interventions that do not consider a client's culture and social context (Davis, 1997; Nobles & Goddard, 1993). Advocacy for increased Africentric discourse on EBP will begin to close this gap. Africentric scholars who want to advance Africentric interventions are encouraged to work in interdisciplinary teams, especially when they are disseminating information or seeking state and federal funding sources. Building professional and research alliances within the field of psychology, specifically among Africentric psychologists and other affiliated professionals, is also important to advancing the scientific discourse on the effectiveness of Africentric interventions.

## CONCLUSION

Although African Americans are widely resilient, many of the problems they face are rooted in impoverished living conditions and stressful life events resulting from historical oppression and loss of culture and identity. Africentric interventions address structural (macro) and individual (micro) challenges to promote well-being and, as such, are consistent with social work's commitment to social justice for vulnerable populations. More efforts should be made to disseminate information about existing Africentric interventions, with emphasis on documenting those that have been evaluated and those that are in need of additional studies, with the aim of developing guidelines for evidence-based Africentric practice. Our work here is a start in that direction. On the evidence of the literature review, a number of programs are achieving success with various African American subpopulations; programs are being implemented by both psychologists and social workers who are committed to working with African American populations. Funding to increase

the number of RCTs will help in developing the necessary evidence of effectiveness. Smaller projects and community-based grassroots programs continue to struggle with funding, but incorporating manualized interventions and control groups at this level would add substantially to the research base. Through documentation of the existing programs, dissemination can lead to replication, and the discourse will be advanced to develop guidelines and further studies of Africentric best practices. Our larger work of capturing the comprehensive scope of Africentric interventions in a single volume will help to facilitate greater dissemination and replication of promising interventions. We hope this article starts a trend of Africentric scholars talking to each other across disciplines, sharing manualized treatments, and working collaboratively to build evidence-based Africentric research. **SW**

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**Dorie J. Gilbert, PhD, LMSW**, is associate professor, School of Social Work, and faculty affiliate, Center for African and African American Studies, University of Texas at Austin. **Aminifu R. Harvey, DSW, LICSW**, is professor, Department of Social Work, Fayetteville State University, North Carolina. **Faye Z. Belgrave, PhD**, is professor, Department of Psychology, director, Center for Cultural Experiences in Prevention, Virginia Commonwealth University, Richmond. Address correspondence to Dorie J. Gilbert, School of Social Work, University of Texas at Austin, 1 University Station, D 3500, Austin, TX 78712; e-mail: [dgm@mail.utexas.edu](mailto:dgm@mail.utexas.edu).

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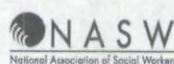
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