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II. SHAME AND HUMILIATION:
THE EMOTIONS OF INDIVIDUAL AND COLLECTIVE VIOLENCE

In Tuesday night's lecture, I reviewed a case of individual violence, a murder that was shocking not only in that it pushed violence to the extreme limit of what physical reality makes possible, but also because it was so senseless and apparently unmotivated, in order to see if in examining this extreme example we might come upon any clues as to what could have caused not only this particular murder but violence in general.

Tonight I want to describe in more detail a psychodynamic theory that I have developed over the years concerning the causes of violence; to show how this psychological theory can both explain and be tested against some sociological data concerning the distribution of violence among different social groups; and finally, to discuss briefly the implications all this might have for the prevention of violence.

Up to now we just have not had a theory of violence adequate enough to guide effective moves toward the prevention of violence and the treatment of violent people. But to say that is not to say that we have not had a theory. In fact, it is impossible not to have a theory on this subject, because we cannot avoid having to deal with violence; and whatever assumptions we make about it constitute at least an implicit or inchoate theory of violence. So our only choice is between having a conscious theory, which we can then examine, question, criticize, and improve; or having an unconscious one, which will remain untested, neither provable nor disprovable, and therefore unimprovable.

In fact, my main hesitation in advancing a new theory of violence is based on the fact that from one point of view the last thing we need is another theory of violence -- for it would not be going too far to say that everyone already has a theory of violence! We could construct another Tower of Babel out of all the theories of violence that surround us, many of which contradict all the others.

One of the most popular theories about violence is the biological one, of which there are several varieties, almost all of which have been disproven. The first that I might mention is the theory that tendencies toward violent behavior are inherited -- which was summed up in the title of a Grade B Hollywood movie that dramatized that theory, called "The Bad Seed." However, the most rigorous tests of that hypothesis, three Scandinavian studies of twins raised apart from their biological families in adoptive homes, as summarized by Sarnoff Mednick, have been unanimous in failing to find a correlation between heredity and adult violence.

Another piece of evidence that violence is not hereditary is the fact that both whites and blacks are more violent in this country than they are in their cultures of origin. European-Americans are far more violent than native Europeans, even though they share the same genetic heritage. European-Australians, by contrast, are not more violent than native Europeans; they also, like us, share the same genetic heritage as native Europeans -- in fact, if anything, the ancestors of Australian whites were selected disproportionately from the most violent European criminals -- but their culture does not breed the same high level of violence that ours does. African-Americans have much higher homicide

rates than European-Americans do; yet native Africans, as long as they are living in traditional cultures that have not been disrupted and humiliated by colonialists, show lower rates of homicide than whites in this country do.

So the evidence is overwhelming, from a variety of sources, that violence is caused by the interaction of social and psychological forces, and that biological variables do not contribute to the causation of violent behavior in any demonstrable or measurable way, except for two that I unfortunately won't have time to discuss tonight -- namely, sex and age. In every culture, and every era of history, males are much more violent than females, and the young, once they reach puberty, are more homicidal than the old; and the evidence is compelling that those differences are caused in part by biological factors such as exposure to fetal androgens during gestation, the explosive increase in circulating levels of androgens after puberty, and so on. But the differences in violent behavior between men and women, and between the young and the old, are clearly also influenced by social and psychological forces, to an even greater degree than they are by biological ones. This means that in order to discuss those differences at all one must integrate data from all three of those disciplines, and I just will not have time to go into that tonight, and still discuss everything else that I want to.

There has also been a lot of publicity recently suggesting that violence may be caused by organic brain damage, epilepsy, and other neurological lesions. However, the consensus among the neurological societies, congresses, task forces, research projects, and reviews of the scientific literature that have studied this question is that no specific,

identifiable, diagnosable neurological lesion, abnormality or syndrome has yet been demonstrated in man to cause the kind of organized, goal-directed behavior that results in violent attacks on others. Epileptic patients will thrash around with automaton-like movements, for example; but they do not attack people. And it is still far from proven that the neurological lesions that cause epilepsy make a significant contribution, on a socially significant scale, to the problem of violence in our society.

The fact that violent people have higher rates of a miscellaneous and rather random mixture of head injuries and seizure disorders is more often a consequence than a cause of their violent life-styles -- that is, if you are always getting into bar-room brawls you are likely to get your head injured, sooner or later -- and it is also a consequence of the violent abuse they suffered as children, which can cause adult violence because of the psychological trauma it inflicts, independently of whether or not it produces any specific neurological lesion. That damage to some areas of the brain, when it is severe enough, can impair judgment and impulse control is of course true; but that any given lesion specifically stimulates violence, in the absence of pathogenic social and psychological forces, has not yet been demonstrated.

Despite all the incompatibilities between the various assumptions about violence that are held by different individuals and groups, there is enough consistency in the way that we as a nation, through our governmental institutions, have been dealing with violence, that I think it is possible to speak of an underlying theory of violence that has been guiding our national response to it -- what I would call the "common

sense/rational self-interest" theory. By that I mean the set of assumptions that are embodied in and enacted by the institutions with which we deal with violence -- our criminal justice system and our military establishment -- which can best be summarized as the theory that those who engage in violence (whether we call them criminals or war-criminals) do so for reasons of rational self-interest and common sense; that like anyone else with common sense, they do not want to go to prison or to war, do not want to be subjected to physical violence themselves, and do not want to die; and will do anything to avoid any of those fates; and that therefore all we have to do to prevent violence and avoid murder and war is to threaten to punish those who would commit such acts with greater violence of our own -- such as imprisonment and capital punishment, in the case of individuals, or "bombing the hell out of them," in the case of nations.

Now, there is nothing wrong with this theory, except for four things: it is totally incorrect, hopelessly naive, dangerously misleading, and based on complete and utter ignorance of what violent people are actually like, of what actually causes violence, and of what could conceivably prevent it. As a result, this theory of violence has had two disastrous and very expensive consequences: first, by leading us to shift our attention and resources from prevention to punishment (on a national scale, to police and prisons; on an international one, to military solutions) this theory has distracted us from attempting to learn what actually causes violence, and what conditions would be necessary in order to reduce the need for violence -- both their violence, and ours; and from applying that knowledge to eliminating or ameliorating those

conditions so that we would actually succeed in preventing violence rather than merely punishing it (by means of more violence of our own) after it has occurred, which amounts to locking the barn door after the horse is stolen.

Secondly, the policies we have adopted on the basis of this theory have not led to a decrease in the amount of violence; on the contrary, they have been followed by an enormous and still escalating increase in it, to the point where there has been more violence in this century than ever before in history. For example, the murder rate in this country has repeatedly risen, to the point where it is now ten times as high as it was at the turn of the century and is still climbing, so that last year we registered the highest murder rate ever recorded in our history -- despite (or, in part, because of) the fact that we now imprison far more of our population than any other country on earth, including even such police states as South Africa and the Soviet Union; and despite the fact that we are now imprisoning more people than we ourselves have ever done before in our history, twice as many as we did ten years ago. Our murder rate is from five to twenty times as high as that of any other industrialized democracy, even though we imprison five to twenty times as high a proportion of our population as any of them do; and despite (or, in part, because of) the fact that we are the only Western democracy that still practices capital punishment. In fact, the only other industrialized nations in the Western hemisphere that still commit legalized murder are the non-democratic police states who are also our closest partners in the use of prisons as punishment, South Africa and the Soviet Union.

Clearly, the result of our increasing use of punishment not only

has not been a decrease in the amount of violence in society; it has been associated with the greatest increase yet. But despite that overwhelming reality there is no indication that anyone in a responsible position of power has felt the need even to question, let alone reject, the official theory.

How can we explain the fact that on a world-wide scale this has been the bloodiest century in all of human history, with the first world-wide wars, the most concentrated genocides, and the invention and use of weapons that for the first time threaten our very survival as a species? What else can we conclude, except that for all practical purposes what we thought we knew may have been so misleading as to be worse than an honest admission of ignorance would have been? The question I want to ask is not whether we have even begun to understand this problem, but rather, why haven't we?

The reason I ask is based on my experience that in sitting down and talking with violent people and asking them why they have been violent, to my amazement, many of them have told me. I don't mean they all do; some, such as the man I discussed on Tuesday, do not tell me in words, and many may not even understand themselves why they committed the violence that sent them to prison. They speak in the symbolic language of the act of violence itself, so that I proceed like a cryptologist cracking a code, or an anthropologist trying to understand the meaning of a bizarre and gruesome ritual. But others do tell me, so simply and directly that I don't need an elaborate interpretation to understand what they mean.

For example, I can't tell you how often the prison inmates I work with have told me, when I asked them why they had assaulted someone, that it was "because he disrespected me," or "he disrespected my visit" (meaning "visitor"). In fact, the word "disrespect" is so central in the vocabulary, and therefore in the moral value system and the psychodynamics, of these chronically violent people, that they have abbreviated it into the slang term, "he dis'ed me."

One prisoner, a very angry and violent inmate in his thirties who was in prison for armed robbery, was referred to me in the Prison Mental Health Service I directed, because he had been yelling at, insulting, threatening and assaulting another inmate. He had been doing this kind of thing for the past several weeks, and off and on for years, and was usually so inarticulate and disorganized that neither I nor anyone else had been able to figure out what he wanted or what was fueling these repetitive acts of violence; nor had I had much success in inducing him to disengage from his endlessly self-defeating power struggles with everyone around him, which inevitably resulted in his being punished more and more severely.

That pattern itself is extremely common in this population, by the way; for in prisons, the more violent people are, the more harshly the prison authorities punish them; and the more harshly they are punished, the more violent they become, so that both the inmates and the prison authorities are engaged in a constantly repeated, counter-productive power struggle that amounts to a mutually self-defeating, literally "vicious" cycle. And what goes on in the prisons is only a microcosm of what goes on in society as a whole -- that is, what all of us have been

engaged in, insofar as our penal and military policies represent us as a society.

In an attempt to break through that vicious cycle with this man, I asked him not just "What do you want?" but "What do you want so badly that you would sacrifice everything else in order to get it?" -- since it seemed to me that by that point that was exactly what he was doing. At that point this man who was usually so inarticulate, disorganized and agitated that it was difficult to get a clear answer to any question, stood up tall and immediately replied, simply and with calmness and assurance, with perfect coherence and even a kind of eloquence: "Pride. Dignity. Self-Esteem." And then he continued, back to his usual vocabulary but with more organization than usual, "And I'll kill every mother-fucker in that cell-block if I have to in order to get it! My life ain't worth nothin' if I take somebody disrespectin' me and callin' me punk asshole faggot and goin' `Ha! Ha!' at me. Life ain't worth livin' if there ain't nothin' worth dyin' for. If you ain't got pride you got nothin'. That's all you got!

"I've already got my pride. He's tryin' to take that away from me. I'm not a total idiot. I'm not a coward. There ain't nothin' I can do except snuff him. I'll throw gasoline on him and light him." He went on to say that the other inmate had challenged him to a fight, and he was afraid not to accept the challenge because he thought "I'll look like a coward and a punk if I don't fight him."

And actually, the main thing one hears from violent people is one variation or another on exactly this same theme. Another similar but

slightly older inmate, a man in his mid-forties, came in to see me because he also had been involved in a running battle with most of the inmates and correction officers on his cell-block. He began his explanation as to why he was doing this by saying that he didn't care if he lived or died, because the screws and the other prisoners had treated him so badly -- "worse than animals in zoos are treated" -- that they had taken all his property away from him and he had nothing left to lose; but what he couldn't afford to lose was his self-respect, because that was all he had left, and "if you don't have your self-respect you don't have nothing." One way they took his self-respect was that another inmate threw water on him, and the officer who saw this happen did nothing to intervene. So the only way he could regain his self-respect, he felt, was to throw water on the officer and the other prisoner -- as a result of which they sentenced him to solitary confinement. He said "death is a positive in this situation, not a negative, because I'm so tired of all this bullshit that death seems thrilling by comparison. I'm not depressed. I don't have any feelings or wants, but I've got to have my self-respect, and I've declared war on the whole world till I get it!"

Some people think armed robbers commit their crimes in order to get money. And of course that is the way they rationalize this behavior sometimes. But if you sit down and talk with people who repetitively commit such crimes what you actually hear is "I never got so much respect before in my life as I did when I first pointed a gun at somebody," and "You wouldn't believe how much respect you get when you have a gun pointed at some dude's face." For men who have lived for a lifetime on a diet of contempt and disdain, the temptation to gain instant respect

in this way can be worth far more than the cost of going to prison, or even of dying.

Should we really be so surprised at all this? Doesn't the Bible, in describing the first recorded murder in history, tell us that Cain killed Abel because he was treated with disrespect! "The Lord had respect unto Abel and to his offering: But unto Cain...he had not respect" (Gen. 4:4-5). In other words, God "dis'ed" Cain! Or rather, Cain was "dis'ed" because of Abel. And, as the anthropologist Julian Pitt-Rivers_ concluded, it is true in all known cultures that "The withdrawal of respect... inspires the sentiment of shame."

I have yet to see a serious act of violence that was not provoked by the experience of feeling shamed and humiliated, disrespected and ridiculed, and that did not represent the attempt to prevent or undo this "loss of face" -- no matter how severe the punishment, even if it includes death. For we misunderstand these men at our peril if we do not realize they mean it literally when they say they would rather be dead or mutilated, or kill or mutilate others, than live without pride, dignity and self-respect. They literally prefer death to dishonor.

For human beings the self, the psyche, is far more important than the body, the soma; and when people feel that the self, and the self-esteem on which it is dependent for its survival, is threatened with destruction, people will quickly and gladly sacrifice bodies, their own or other peoples', in the attempt to prevent or undo this most catastrophic of all human experiences, the death of the self.

As Frantz Fanon put it, "hunger with dignity is preferable to bread

eaten in slavery." Hannah Arendt, in her essay On Violence, criticizes this remark as one of Fanon's "worst rhetorical excesses," and adds that

> No history and no theory is needed to refute this statement; the most superficial observer of the processes that go on in the human body knows its untruth. But had he said that bread eaten with dignity is preferable to cake eaten in slavery the rhetorical point would have been lost._

Nevertheless, my own observations of the hunger strikes that prison inmates go on when they feel their pride has been irredeemably wounded, and they see refusing to eat as their only way of asserting their dignity and autonomy and protesting the injustices of which they perceive themselves to be the victims, suggests to me that Fanon was expressing something that is a psychological truth for the most violent men: namely, that those who engage in these desperate (and potentially suicidal) manoeuvres do feel that "hunger with dignity" really is "preferable" to "bread eaten in slavery" -- physiology be damned! Those whose pride has not been so demolished would not find starvation preferable, and therefore find it hard to understand this, because they have other sources of pride; but what was true for them is simply not true for the kinds of people Fanon and I are talking about.

Perhaps the lesson of all this for society is that when people feel impotent and humiliated enough, the usual assumptions one makes

about human behavior and motivation, such as the wish to eat when starving, the wish to live or stay out of prison at all costs, no longer hold. Einstein taught us that Newton's laws do not hold when objects approach the speed of light; what we now need to learn about humans is that the "instinct of (physiological) self-preservation" does not hold when one approaches the point of being so overwhelmed by shame that one can only preserve one's self (as a psychological entity) at the sacrifice of one's own physiological survival (or of the survival of others).

In other words, we need to remember that for the most violent people "self"-preservation is not synonymous with preservation of the body, as is usually assumed, and as it in fact is for those who are non-violent. But for the violent, "self" does not mean "body;" the two become "dis-jointed," so to speak, so that the interests of the two may be irreconcilably opposed, and the value and priority placed on each may be antithetical.

Nevertheless, for those who do value physical survival, violence is by many criteria the most important public health problem currently confronting us. For example, violence is overwhelmingly the most frequent cause of premature death; and since it primarily kills the young, whereas heart disease and cancer mainly end the lives of those who are approaching the end of the life span, violence causes far more years of potential life lost in this country before the age of 65, than are lost because of cancer and heart disease combined! And yet incomparably more research dollars are spent on the study of patients who suffer from those illnesses than are spent studying the individuals in our prisons and prison hospitals who suffer from a far more deadly form of

pathology.

The main thesis that I want to propose to you tonight is that the different forms of violence, whether toward individuals or entire populations, are motivated, or caused, by the feeling of shame. Violence toward others, such as homicide, is an attempt to replace shame with pride when non-violent means such as economic or cultural achievement are not perceived as attainable.

Finally, the thesis I am proposing here concludes that the target toward whom the violence is directed -- that is, toward oneself or toward others -- is further influenced by the presence or absence of the capacity to feel guilt, as it interacts with shame in a complex psychodynamic, psychocultural and psychophysiological system. When guilt is present, it motivates the individual to direct his violence toward himself, as in suicide -- though shame may also motivate suicide, if circumstances such as imprisonment, or defeat in war, prevent a person from discharging his violence onto others, and he sees no other way to put an end to an intolerable humiliation. The suicides of Antony and Cleopatra, defeated Japanese samurai committing hara-kiri, and many of those who commit suicide in prison, are of this type.

Shame and guilt, as Franz Alexander was the first to recognize, are dynamic opposites and antagonists, like the sympathetic and parasympathetic nervous systems (with which they in fact interact physiologically, as in blushing), so that whatever experiences increase the one decrease the other. For example, punishment and suffering relieve guilt but intensify shame. (As D. H. Lawrence said, "I don't want

to suffer.... I should be ashamed. I think it is degrading."[1] The fact that punishment decreases guilt is why penance relieves guilt feelings, at least temporarily. The fact that being the victim of violence or punishment increases feelings of shame and decreases feelings of guilt helps to breed criminals; this is why those who have been punished most severely -- whether by means of violent child abuse, or by means of the most punitive penitentiaries, are unable to experience feelings of guilt no matter how guilty they are of hurting others. Shame is also increased by exposure of one's weakness, incompetence, vulnerability or neediness, so it motivates concealment (as in lying).

From a dynamic point of view, shame is a motive of defense against wishes to be loved and taken care of by others, wishes that make one vulnerable to the risk of rejection, that prototypically shame-inducing experience. These wishes to be loved and taken care of remain strong, and hence shame-provoking, to the degree that they have never been satisfied by the community, or lack of one, into which the individual was born.

To the degree that shame is operative, it motivates people to frustrate those wishes and even to conceal their existence (especially from themselves), often by going to the opposite extreme. When that happens, the impulses shame motivates as defenses against those wishes will be the opposite of those being defended against. Thus, shame-provoking wishes to be loved and taken care of by others will be concealed behind the defensive facade that replaces them, namely, active

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[1] Women in Love

aggressive impulses of hate directed toward others. What is so unfortunate is that there are few more effective means of disguising the wish to be loved and taken care of; this defense -- the defense that violent behavior constitutes -- is all too successful in concealing, both from himself and from others, the individual's need to be loved and cared for.

Guilt, by contrast, is a motive of defense against feelings, wishes and impulses of hate toward others -- those wishes which are the very "defenses" stimulated by shame. The defensive attitudes and behaviors motivated by guilt are the opposite of those being defended against; in general, they can be understood as going to the opposite extreme against hostile and violent impulses, and may take the form of exaggeratedly self-sacrificing altruism, obsessive self-criticisms, behaviors that are self-defeating or whose purpose is to provoke others to punish oneself (which Freud called "moral masochism"), and inhibitions even of non-violent activity, aggressiveness, independence and ambition (such as prohibitions against success).

Shame motivates hostility toward others, which is usually limited to hostile thoughts and feelings but can culminate in hostile behavior as well, escalating to violence when nothing else is perceived as being capable of rescuing self-esteem or national honor. The purpose of violence is to restore and maintain respect for oneself or the social group with which one has identified (family, class, race, ethnic group, religion, nation) when the self or the group is perceived as having been shamed, insulted or treated with disrespect. People need a certain minimal sense of pride and dignity, since to be overwhelmed by feelings of personal or

national shame and humiliation is experienced psychologically as tantamount to the disintegration or death of the self or (what amounts to the same thing) of the group one has identified oneself with; and it is characteristically accompanied by the feeling, and the fear, of that dissolution of the self termed (by people going through the experience) "going crazy."

In fact, violence, including homicide, is for many people a desperate attempt -- sometimes successful, sometimes not -- to ward off that ultimate disintegration of the self called madness. Extremely violent people, if one sits down and talks with them, can describe these phenomena quite simply and clearly. For example, I spoke with an inmate recently who was recuperating from multiple fractures of the jaw that he had suffered when another inmate beat him up. When I asked him what he was planning to do now, he said that he would "go after" the man who had injured him -- break his jaw, or worse. When I asked what was the worst thing that would happen if he did not get revenge, he replied that he would "lose respect" from other inmates (and ultimately, his self-respect). When I asked him what was the worst thing that would lead to, he replied, "I can't take it; I start going crazy;" and he went on to describe the sense of chaos, disorganization and panic that he experiences until he redresses an insult or revenges an injury. Compared with that state of his psyche, a little injury to his (or the other person's) soma, or even a lot of injury (up to and including the physical death of himself or the other person) seems a small price to pay for the rescuing of his self-esteem -- or, to put it more exactly, the rescuing of himself. What appears to an outsider as the creation of chaos and the

breakdown of "law and order" represents in terms of his inner psychological functioning the attempt to ward off chaos and restore order and homeostasis -- which he feels he can do only by means of violence.

[Cf. "Dead Birds": same there, but collective.]

Perhaps the simplest way to sum up the theory of violence I am presenting here is to say that the most direct way to stop others from laughing at oneself (which is what people who feel ashamed perceive is happening, whether it is or not) is to make them weep instead; and the easiest and surest way to accomplish that is by means of physical violence. Shakespeare illustrates this brilliantly and literally in the scene in Henry V in which the French King ridicules Henry by sending him a gift, not of royal treasure, but of tennis balls. Henry replies to this ridicule, or mockery, with the ultimate violence, a declaration of war on France, with which to replace French laughter with tears:

> ...tell the pleasant prince this mock[ery] of his
> hath turn'd his balls to gun-stones ...
> His jest will savor but of shallow wit,
> When thousands weep more than did laugh at it. (I.ii.281-96)

It is true that creating, achieving or producing things that are valued by other people can command respect and lead to honors, prestige, status, wealth, and power, and that this can be an equally effective and even more permanent means for warding off ridicule than violent behavior can. As Gerhart Piers put it, the experience of competing successfully, or achieving enough to attain one's level of ambition or aspiration, can heal the wounds to self-esteem that shame

consists of. Unfortunately, achievement and creativity require time, patience, talent, education, and some minimal degree of social and economic advantage, as well as sheer good luck; and many people, and many peoples, have not had such fortunate combinations of both internal and external resources -- whereas violence always lies ready to hand (literally).

THE SOCIOLOGY OF VIOLENCE

From the standpoint of public health a pressing question now is: what are the social conditions, on a socially significant scale, that lead people to feel so overwhelmed by shame or guilt as to resort to violence against others or themselves? There are several problems with attempting to identify which groups are subjected to disproportionate degrees of shame or discrimination, or of being treated as inferior or of lower caste, without tending to see that group only along the dimensions of its victimization, rather than also acknowledging its successes, and thus we add yet one more insult to those to which it has already been subjected. And, for example, it is rather absurdly ironic, in one sense, to discuss the African-American community as one that suffers from an unusually high level of violent crime, when the most impressive and influential advocate and exemplar of non-violence is our history was a black man, Martin Luther King Jr. It is even more ironic when we reflect that blacks are, and always have been subjected to far more violence from whites than they have themselves ever committed against whites -- from the centuries of the slave trade, in which literally millions of kidnapped Africans were subjected to lethal conditions of transportation and labor, to their current decimation by the deadliest form of violence of all, as Gandhi correctly recognized, namely, poverty (or "structural violence," as it is increasingly being called, since it is a product of the socio-economic structure of society) -- which kills far more blacks in this country than all the murders yet committed.

On the other hand, because the main victims of that kind of violence that is called criminal are other blacks, leaders of the African-

American community themselves have been among the most vocal in calling attention to the importance and the dimensions of this problem, so I will proceed. And I believe even a brief analysis of this problem will illustrate the power of systematic shaming and humiliation as a cause of violence.

The psychoanalyst Edith Jacobson observed that "people may feel ashamed of low financial or social or racial status." The very fact that the words "low" and "status" are used to describe these differences -- as in the term "lower class" -- tells us which population groups in our society are more exposed to experiences of shaming. Who would not feel ashamed and inferior if described as "lower class" or of "lower status"? The Latin word for "lower" is inferior; of "upper," superior. Likewise, the Latin word for "lower class" is the root of our word "humiliation." For example, as Sir Moses Finley has pointed out, "In the 2nd cent. A.D., ...a formal distinction [appeared in Roman law] between honestiores and humiliores, which can be roughly rendered as `upper classes` and `lower classes'._ The term honestiores, by which the upper classes were denominated, is a derivative of the word honor, which in both Latin and English is the condition conducive to feelings of pride. Similarly, the words for "proud" and "pride," superbus and superbia, have the same root as superior, or "upper;" their literal meaning is that to be proud, to experience pride, is to "be above" others -- as in being upper class. In other words, the very language we use reveals how much we give honor and pride, prestige and status to the upper (superior) classes, just as our language contains within itself the feelings of humiliation and inferiority experienced by those whose social position is humble and inferior.

That these are psychological as well as etymological truths is borne out by empirical investigations of the differential exposure to feelings of shame and guilt in the different social classes. For example, Langner and Michaels in the Midtown Manhattan Study (1964) found excessive shame and minimal guilt in the lower-status groups, and excessive guilt and relative protection from shame and humiliation in the upper classes. In the slums, they concluded, "social control is by shame, ridicule or threat of punishment." Among the higher-status groups they found "social control primarily by creation of guilt; less shaming or disparagement." Differences in child-rearing methods between the different groups contribute to these different outcomes, but so do social experiences throughout the rest of the life cycle. For example, "any lower-class parental rejection will be reinforced by societal rejection in adult life, while the compensations of status, power and other gratifications may be accorded the wealthier individual, thereby counteracting his earlier rejections." They refer also to the damage the lower-status father's inferior social position does to the child's self-esteem, and conclude that his occupation is "despised or causes shame and embarrassment." Among children from upper-status homes, in contrast, "parents' occupation is respected, leading to strong identification."

Simpson (1960, p. 305) reported the same finding, and quotes one man as saying:

> When I was in the sixth grade a neighboring woman told me that she considered my father's occupation rather scummy and that she did not want her children contaminated by association with

> me. ...I came to feel a sense of shame and embarrassment about my father's job, not because of the lack of money, but because of the lack of status. I recall being very impressed with the status of occupations of other parents and secretly wishing that my father could achieve that status so that I could impress other boys and girls.

It should be emphasized that it is not poverty or deprivation per se that causes shame, but relative deprivation. Even the man who denounced the exploitation of the poor more powerfully than anyone since the prophet Amos, Karl Marx, saw that it was not living in a hovel that humiliated people, but living in a hovel next to a palace. That is why he described "shame" as "the emotion of revolution" (from the point of view, which was always his point of view, of the poor).

Not surprisingly, if we compare blacks with whites in this country or others in which blacks have been victimized by racial discrimination, we find the same relative differences. Frantz Fanon, for example, the revolutionary psychiatrist in North Africa, described his response to being black in a world dominated by whites: "Shame. Shame and self-contempt." He quoted the poet Aime Cesare who wrote "What a disgrace it is to be black in this world! ...I rise burdened with the shame of my color," and another who wrote: "My Christian name: Humiliation!" The situation is no different here. The psychiatrists Grier and Cobbs wrote in their book Black Rage of "the endless circle of shame, humiliation and the implied unacceptability of one's own person" that many blacks in this country experience. Kenneth Clark's classic studies investigated the emotional situation black Americans are in as they emerge from

childhood experiences of being treated as inferior. He concluded: "The stigma remains; they have been forced to recognize themselves as inferior. Few if any Negroes ever fully lose that sense of shame." The U.S. Supreme Court drew on Clark's research to support the desegregation decision, Brown v. Board of Education (1954). As the Court put it, "To separate [black children]...solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone."

Whites, by contrast, are differentially exposed to conditions that create a greater likelihood of feeling both pride (because of born into positions of superior power, wealth and status), and guilt (because of using that power to treat blacks in a manner that it is almost impossible not to perceive as both unjust and injurious). One does not need to assume any innate difference in the capacity for or sensitivity to either shame or guilt on the part of the two races; rather, the objective conditions of life for the two races in this country would seem virtually to guarantee that whites would be more exposed to feelings of guilt, and blacks to more feelings of shame and humiliation.

For, as Henry and Short pointed out in their classic study of Suicide and Homicide (1954), the greater the degree of advantages, power and freedom a person has, the likelier he is to perceive himself as having only himself to blame whenever things go wrong (as they inevitably do for everyone, at one point or another); whereas those who cannot help but be aware how little control they have over many of the setbacks and disadvantages they suffer would virtually have to be out of touch with reality to blame themselves for most of their problems.

Before I even begin to discuss the problem of violence in the African-American community, I need to preface it with several reminders. The first is that the amount of violence done to African-Americans is, and always has been, incomparably greater than the violence done by this group.

In the light of all this, it is hardly surprising that those groups with a higher ratio of shame to guilt would have a higher ratio of homicide to suicide. Henry and Short reported that for blacks in this country the ratio of homicides to suicides (7 to 1) is 35 times higher than the corresponding ratio among whites (where it is 1 to 5, in the opposite direction -- that is, one homicide for every 5 suicides). Or, comparing the homicide rates alone, among blacks in this country it was 11 times as high as the rate among whites (and even higher, in some studies; Wolfgang's 1958 monograph, Patterns of Criminal Homicide, found the black homicide rate in Philadelphia to be 14 times as high as the white rate).

As I said earlier, studies of a number of native African populations whose cultures were still intact, as reported in the anthropologist Paul Bohannan's African Homicide and Suicide, have shown homicide rates that were well below those among blacks in this country; in fact, many of the cultures had homicide rates lower than those found among whites in this country. These data make it clear that homicide is not a function of race, or biology, but of social circumstances; and they suggest that black violence in this country is caused by white racism. (And, I would add, the intervening variable is shame.)

On the other hand, whites in the U.S. are roughly three times as likely as blacks to commit suicide, as we would expect if guilt is statistically more likely to motivate the introjection of anger, and whites are more likely to see themselves as being guilty (relative to blacks).

Comparing lower- with upper-class homicide/suicide ratios, we find the same inversion, though not quite as extreme (for one thing, definitions and measurements of social class, which is always a continuum from lower-most to upper-most, are much more variable than are those of race, which is easier to conceptualize as all-or-nothing). Despite these difficulties, however, there is a consensus that the lower-class homicide/suicide ratio is 10 to 20 times higher than the upper-class ratio (depending on the study, and how "upper" or "lower" the class is). The homicide rate in every study I have come across is from four to nine times higher among the poor than among the rich. The association between suicide rates and social class is more variable, though even those that find the highest rates of lower class suicides still find that the ratio of homicides to suicides is, as I said, significantly higher among the poor than among the rich.

In other words, there is a great deal of evidence that the social conditions and influences that different groups are subjected to are just as powerful in determining the differences in rates and types of violence between those groups, as psychological influences and conditions are in determining the differential predisposition to violence between different individuals within each of those groups.

What I will attempt here is to go beyond that conventional wisdom

and show how the social causes of violence are linked to, and in fact are identical with, the psychological causes, namely, increased exposure to feelings of shame and decreased exposure to feelings of guilt. One advantage of this approach is that it makes it possible not only to integrate the clinical and psychological knowledge that we have about individuals with the sociological data that we have about groups into one inter-disciplinary theory of violence; also, this theory solves a puzzle that has been a stumbling block in attempts to explain violence for many years.

The puzzle I am referring to is this: it has been known for millennia that individual or inter-personal violence -- i.e., murder and other acts of violence that have been defined as crimes by the ruling class of any given society -- are strongly associated with poverty, i.e., with the so-called lower classes. Long before there were statistical demonstrations of this association, both Plato and Aristotle said that poverty is the mother of crime; and our language itself reveals this perceived association. For example, our word "villain" originally meant simply a serf, that is, an inhabitant of the village, or collection of farm houses, that surrounded the villa, the country house or manor in which the lord of the manor resided. Conversely, the terms used to refer to the upper classes have always had a positive moral and legal connotation. The term for the upper classes in ancient Roman law, honestiores, is the root of our word "honest;" and the term "noble" likewise implies both aristocratic social status and moral superiority.

But the problem with seeing poverty or racial discrimination as "causing" crime, and upper social status as providing immunity against

it, is that even though there is a demonstrably higher incidence, or probability, of the kinds of violence that are defined as criminal in those groups that have lower social and economic status, it is just as true that most poor people and most African-Americans do not commit such crimes; and that some, although fewer, members of upper status groups do commit them. How can all this be, if poverty and discrimination "cause" violence?

The theory I am proposing here suggests a solution to that puzzle, namely, that it is not poverty, nor even relative poverty, relative deprivation, per se, that causes violence; rather, violence is associated with poverty statistically, or probabilistically, but only probabilistically, because poverty itself is associated probabilistically, but only probabilistically, with the intervening variable which is much more directly causative of violence, namely, shame and humiliation. In other words, more poor people become violent, although most do not, because being poor increases the probability, in a statistical sense, that one will be exposed to higher frequencies and intensities of insult and contempt, of being humiliated and treated as inferior (as the Latin terms for "lower" class imply linguistically), as compared with those of upper social status, and that therefore there will be a higher risk of being overwhelmed by feelings of shame and not having available to oneself those other sources of pride and self-esteem, such as money, power, and social prestige, which can serve as alternatives to violence in satisfying the universal need for self-respect and respect from others.

But it is also clear that most people, even those of lower social status, do have other sources of self-esteem besides violence; and just as

true that even higher social status is no absolute protection against being shamed, rejected or unloved, or of failing to achieve whatever level of aspiration one needs in order to be able to feel self-respect and avoid feelings of inferiority, failure, or incompetence.

In other words, you don't have to be poor or discriminated against to be shamed and experience feelings of inferiority -- but it helps. And social prestige and high social status do not guarantee you protection from being treated as, and feeling, inferior -- but they help.

So poverty and discrimination per se are neither sufficient nor necessary causes of violence, and they are also neither sufficient nor necessary causes of overwhelming shame; but being poor and discriminated against do increase the probability of becoming violent, and the reason they do so is because those social conditions increase the probability of being shamed, or treated as inferior, and having fewer alternatives to violence in the attempt to avoid the death of the self which results from being overwhelmed by shame.

Finally, in this theory shame itself is conceived as a necessary, but not a sufficient, cause of violence. That is, everyone who becomes violent does so because he or she is attempting to ward off or undo feelings of shame and humiliation, of insult, disrespect or loss of face. But experiences of shame and embarrassment are everyday experiences for everyone, though the frequency and intensity of them vary enormously from one individual or group to another, as does an individual's or culture's sensitivity and vulnerability to such feelings. Nevertheless, the vast majority of such experiences are not followed by, or in other words

do not cause, violent behavior. For shame to cause violence, the person (or group) must be both exposed to and vulnerable to extreme frequencies and intensities of shame, and must have insufficient personal or social resources available to serve as alternatives to violence.

Why do some individuals from lower class backgrounds become violent, whereas others do not? These individual exceptions to the sociological, statistical rules can be explained in terms of what we know about how their individual psychological experiences have differed from those of the non-violent members of the same groups. And those differences invariably consist of increased exposure to shame and humiliation. For example, one study of 31 multiple and mass-murderers by Shervert Frazier and his colleagues reported that the individuals who grew up to commit these murders differed from their non-violent siblings by virtue of the fact that they were singled out in their families for exposure to shame and humiliation almost like scapegoats, as the "whipping boys," so to speak, on whom the families' needs to taunt and tease and ridicule was discharged. As they put it, "The recurrence of a pattern of verbal shaming and humiliation by parents before [the] children's friends and other family members was recounted frequently and corroborated by family members. ...the high incidence of significant and repeated personal humiliation and sense of powerlessness and personal inadequacy cannot be overlooked. The usual pattern is a series of repeated and memorable humiliations accompanied by severe feelings of shame at the seeming personal inadequacy to extricate oneself from a powerless position."

Stuart Palmer's Study of Murder also found that those family

members who grew up to commit murder differed statistically from their non-violent brothers -- that is, siblings of the same sex living in the same family -- by virtue of having a significantly higher incidence of congenital or acquired facial or other physical deformities of the type that lead to feelings of shame and embarrassment (what Erving Goffman refers to when he speaks of "stigma"). They also were significantly more likely to have been subjected to another source of feelings of humiliation, weakness, disrespect and rejection, namely, severe physical beatings.

Conversely, individuals who belong to groups of higher socio-economic status are also capable of being overwhelmed by feelings of shame and feeling so lacking in other alternative means of bolstering their self-esteem that they then become violent -- though that particular combination of circumstances is less likely, in a statistical sense, to happen in such groups. One example of this from my experience was a 20-year old man who was admitted to the prison hospital at Bridgewater when I directed it in the late 1970's, who was certainly of upper social status -- his father had been a clergyman in the most socially prestigious denomination in one of the most socially prestigious WASP resort communities on the East Coast, until he disgraced the family by running off with one of his married parishioners, as a result of which he was defrocked as a minister. The son, even before that happened, had a long history of being the family failure, a disappointment to his parents and clearly inferior to his better-adjusted siblings. He did poorly in school, was rejected by his peers, and finally, after attempting suicide by driving his car over a cliff, he was admitted to one of the Harvard teaching hospitals. Psychological testing was done, and the report stated

"he feels as if he had not lived up to parental expectations. His shame over failing is overwhelming to him." Although according to the thesis I am presenting here that last sentence should have been a red flag warning of danger, the examiner stated that in her opinion "this patient's potential for violence is not significant." Less than a year later he murdered his father, after being slighted and rejected by him; and a few years later, the boy followed that by killing himself as well.

There are many more [ ] painful and important lessons to be learned from this series of human tragedies than I will have time to explore here tonight. The only point I will attempt to make now is simply that even being a member of an upper social status group does not guarantee that one will not experience the utter depletion of self-esteem that this young man did, if one's own individual humiliation goes too deep to be compensated for, or cushioned, by the social prestige of the group to which one belongs. Nevertheless, the likelihood that any given individual will undergo these experiences is strikingly smaller in such a group than it is in those in which the group itself is treated as inferior.

In other words, all the individual members of upper status groups tend to be treated as superior until proved inferior; and all the individual members of lower status groups tend to be treated as inferior until proved adequate, or competent -- and they are less likely, statistically, to be treated as actually superior, even with high levels of achievement.

I am attempting to understand not only why violence is more frequent in lower status groups, but also why it is neither universal in nor limited to those groups. And I am trying to explain why violence,

when it occurs, is invariably caused by shame, but also why feelings of shame per se only rarely result in violence -- that is, only under those (fortunately, rare) circumstances in which the intensity and frequency of the experiences of shame threaten to overwhelm the individual's ability to tolerate those feelings without suffering the death of the self, and in which the individual does not have adequate alternatives to violence, either internal sources of self-esteem and self-respect, or such social resources as power, wealth or social prestige, with which to avoid this most catastrophic of all human experiences.

* * * * * *

Finally, what are some practical implications of all this? What social policies do these considerations suggest would be most effective in preventing violence?

First, to reduce the amount of violence in the world means to reduce the amount of shame; to reduce the amount of shame means to reduce the intensity of the wishes that stimulate shame; and to reduce the intensity of those wishes means to gratify those wishes, by actually taking better care of each other, and especially the neediest among us, than we have been -- particularly beginning in childhood, when those needs are most intense and peremptory, and the effects of frustrating them can be most permanent and ineradicable. As W. H. Auden put it -- and the literal truth of his words cannot be exaggerated in this era of nuclear weapons in which violence threatens the survival of all of us -- "We must love one another or die." Or, to quote the phrase that Dostoevsky put in the mouth of Father Zossima, we must recognize that

"all are responsible for all."

We have a horror of dependency as a nation. We act as though the wish to be taken care of and to be loved is shameful. No wonder we have so much violence. For the horror of dependency is what causes violence. The emotion that causes the horror of dependency is shame. Shame motivates the use of violence, or in other words, active aggressive independent behavior, as the means by which to disguise one's wish to be taken care of by others, and of one's wish for others' love. And the horror of dependency, which shame causes, motivates the repression of those wishes.

One form our horror of dependency takes is a horror of what is somewhat misleadingly called "welfare dependency." Because we are so horrified by "welfare dependency," we as a nation do less for our own citizens than does any other democracy on earth; less to provide the various kinds of care that we all in fact need -- health care, child care, housing, support to families, and so on. It is not surprising that we also have more violence than does any other democracy on earth, as well as more imprisonment.

For while shame motivates the repression of the wish to be loved and taken care of, by concealing it behind exaggeratedly active and aggressive "macho" behavior, what is repressed always returns, in one form or another -- whether it is the government or the individual that represses those needs. One of the discoveries I was most surprised to make about violent people is that chronic institutionalization, in the form of imprisonment, is a means by which shame-driven personalities

arrange to get themselves taken care of, but in a form disguised enough to enable the individual to save face. In other words, the tough, threatening, belligerent behavior that gets people committed to prisons or prison mental hospitals is a face-saving way (sometimes conscious and sometimes not) of arranging to have others meet their needs to be taken care of in ways, and to a degree, that they are too ashamed to acknowledge openly.

For example, the first violent criminal I ever saw in therapy told me after almost a year of regular meetings that when he was "on the street" (meaning out of prison), he would get so tired of being cold and hungry and homeless, sleeping in parked cars or hallways, that he would start missing prison, where he at least got three hot meals, a warm bed to sleep in, and someone who cared enough about him to make sure he was there at night! All he had to do to get those needs met was to commit an armed robbery, along with a mugging that was brutal enough that the judge gave him a reasonably lengthy sentence. On the other hand, to anyone who is aware of what brutal and depriving places prisons are, there is no more severe indictment of the lack of any real "community" in our society, than that some people living in this so-called community would actually find prison preferable. We say "Community, Community," but there is no community.

One of the main purposes of violence, then, is to disguise these basic human wishes so that they can arrange to have them satisfied in a face-saving way -- by being sentenced to a prison or hospital for an act of violence. That way, one can be cared for, can have one's daily needs met, without having to acknowledge publicly, or to oneself, that that is

why one arranged to have oneself institutionalized. One can pretend instead that one is in an institution only because one is so tough and dangerous and scary, so active and aggressive, and so independent of the community's standards, that the courts insisted on locking one up against one's own wishes-- rather than that one has become institutionalized because one is really a person who primarily wants to be taken care of and loved.

Those are among the reasons why the most effective way to increase the amount of violence and crime is to do exactly what we have been doing increasingly over the past decade and more -- namely, to permit -- or rather, to force -- more and more of our children and adults to be poor, neglected, hungry, homeless, uneducated and sick. What is particularly effective in increasing the amount of violence in the world is to permit the increasing gap between the rich and the poor to continue to widen; we have not restricted that strategy to this country alone, but are practicing it on a world-wide scale, and we can well expect it to culminate in increasing levels of violence, also on a world-wide scale, throughout the indefinite future, even if we were to reverse our current policies overnight. That is, even then we could expect the violence to continue until enough generations have passed that the effects of this phenomenon on the current generation of children throughout the world is no longer being felt by their children, and their children's children, and so on ("to the seventh generation" is, I believe, the Bible's estimate of the time scale involved).

Relative poverty -- poverty for some groups coexisting with wealth for others -- is much more effective in stimulating shame, and hence

violence, than is a level of poverty that is higher in absolute terms but is universally shared. That is, shame exists in the eye of the beholder -- though it is more likely to exist there if the beholder is perceived as richer and more powerful than oneself. In that archaic, pre-scientific language called morality, this gap is called injustice; but most people throughout the world still think in moral terms, and the perception that one is a victim of injustice is what causes shame, which in turn causes violence.

From the standpoint of public health, then, the social psychology of shame, guilt, discrimination and violence becomes central to any preventive psychiatry. I hope that my analysis of the psychological consequences of the feelings of shame and guilt has shown how such seemingly trivial events as personal experiences of slights and slurs, chagrin or embarrassment, can explode into epidemics of violence, just as the physical consequences of organisms as insignificant as microbes can have the gravest implications for public health. The task before us now, as I see it, is to integrate the psychodynamic understanding of shame and guilt with the broader social and economic factors that intensify those feelings to murderous and suicidal extremes on a mass scale. If cleaning up sewer systems can prevent more deaths than all the physicians in the world, then perhaps reforming the institutions that systematically humiliate people can do more to prevent violence than all the preaching and punishing that have been the main methods used heretofore by the criminal justice system, and more than all the therapy that all the psychiatrists in the world could possibly provide. I hope that some of the thoughts I have presented here can help to clarify the issues

involved, and that we can join with each other in the effort to attain that goal.

To: First Lady's staff

From: Melissa Ludtke
Public Policy Fellow
Radcliffe College

Re: Follow-up memo to conversations with the First Lady about children/family issues

March 28, 1995

This memo is a compilation of ideas discussed during several meetings I've had with the First Lady, and a suggestion about a strategy I am proposing for her continuing involvement in issues impacting the lives of U.S. children and their families.

During our meeting in February, Hillary and I talked for quite a while about the media's increasing interest in the coverage of children's issues. I shared with her a report done by the Casey Journalism Center for Children and Families; it shows that during the past five years some 35 or so newspapers and news services have added children and /or family beats to their coverage. We talked about how a lot of these reporters now covering children/family issues are eager, because of wanting to develop their beats, to find "serious" news stories to justify and enhance their newspaper's commitment to such coverage.

My point in mentioning this to Hillary was to establish the presence of a growing contingent of reporters and writers, and editors who are all recent converts to the coverage of children. These reporters are not part of the inside-the-beltway press corp but are scattered around the country, trying in various ways to bring news coverage of children and families to readers and viewers. In many instances, given the newness and scope of their assignment, these reporters are not yet knowledgeable about the full range of issues involved in children's lives. Nor do many of them have the kind of opportunity they should to be exposed to the valuable information being unearthed by physicians, social scientists, educators, and neurobiologists about children's needs for healthy development. Instead, many news stories about children arise only out of rancorous political argument about legislation such as welfare reform, in which children become used more as rhetorical devices than as the people whose well-being ought to be the driving force in shaping the debate.

What I proposed to the First Lady - and am now put ting on paper for your consideration - is the development of a well-thought-out strategy by which Hillary's vast knowledge about and experience with children's issues, as well as her extraordinary ability to focus public attention and inform public opinion, is utilized in a national effort to educate Americans [and this new crop of reporters and editors] about the immediate, vital need to find common ground in a campaign to improve the lives of all children.

Let me begin by saying what this strategy is NOT.

It is NOT an attempt to have her assume a new and visible policy making role in the administration
It is NOT an attempt to have her spend time up on Capitol Hill visibly appearing to impact legislation
It is NOT an attempt to have her delineate a large governmental solution to problems of children's poverty, etc.

In this strategy, the First Lady's role would be as:

A CONVENER for experts about what is happening in children's lives, to focus a spotlight on the key developmental ingredients which too many children don't have in their lives

A LISTENER to what experts are able to tell us about what each and every child needs to develop into a healthy and productive adult

A GUIDE to take the American people on a voyage of discovery about how some communities have responded well to the needs of children

What I propose is to create a strategy by which the First Lady appears AT THE HUB of an multi-faceted outreach effort to inform and educate the American people about the key developmental issues in children's lives.

How to do this: When we envision a child's life, we think of it as beginning at birth [or before birth] and moving through various developmental stages on its way to adulthood. These developmental stages can be roughtly divided into four parts [for the sake of this discussion]:

Zero to Three: Infant to Toddler
Four to Eight: Preschool to Elementary
Eight to Twelve: Elementary to Pre-Adolescent
Twelve to Seventeen: Adolescence

My suggestion is that intermittently, during a period of four to five months [maybe from July until December 1995], the First Lady would take the American people on a well-coordinated journey of discovery about what constitutes healthy development for a child in each of these stages. And there is no lack of medical and education experts, such as T. Berry Brazelton [to name an obvious one] who would be delighted to work alongside the First Lady to bring what they know about this to the American people.

For example, in the initial section, when we focus on the Zero to Three years, Hillary - AT THE HUB of this effort could highlight a wealth of fascinating and important new findings about what happens in an infant/toddler's brain. Now that scientists can, for the first time, actually peer inside of a child's developing brain and see the formation of synapses which determine his/her future intellectual growth, they are also finding strong links between what happens [or fails to happen] inside the brain with the environmental stimulation and nourishment a baby receives.

The Carnegie Corporation's report "Starting Points" drew attention to the importance of these new findings in 1994 but neither that report nor this information has been widely disseminated or stressed to legislators who are, for the most part, ignorant about such findings. Also, I gave Hillary [and Liz Bowyer] a five-part, Pulitzer-award winning Chicago Tribune series from 1993 which was about brain development. In these articles the author noted that during the past decade scientists have learned more about the human brain than in all previous history. Pioneering studies, the reporter tells us, show the IQs of children born into poverty can be significantly raised by exposure to toys, words, proper parenting and other stimuli. It is important that what these scientists are learning be also learned by the American people who must make decisions about how we, as a society, invest our resources.

By bringing together a group of articulate scientists whose work is on the cutting edge of this research, the First Lady would inject into this on-going partisan debate the kind of solid information [and persuasive and powerful visual images of brain development] which is woefully lacking. Present also could be early childhood development experts from the worlds of psychology and education to address from their perspectives what can happen to divert healthy development in a child during these years.

I have discussed with Hillary the idea of convening such a group - not unlike the President's pre-inaugural economic summit in Little Rock - getting C-Span to televise it, and issuing findings from it as a public service to the American people. Dr. Barry Zuckerman, a member of

the National Commission on Children, a pediatrician and researcher and head of Boston City Hospital's division of Developmental and Behavioral Pediatrics, told me that this information about early brain development and the visual evidence he's able to show people are the most powerful and persuasive tools he's ever found in convincing people of the need to pay attention.

Each of these four developmental stages offers fertile ground for gathering new and important findings regarding children and families, and highlighting them for both reporters and the public who are astonishingly ill-informed. [I won't detail each one of them now, but suffice it to say there is more than enough material for the First Lady to spotlight - such as, in the pre-adolescent and adolescent stages, her concern about drawing attention to the impact of violence in the lives of children.] And while this strategy keeps the First Lady away from explicitly entering the fray of public policy debate, her ability to place a frame of public policy around this information and inform basic principles which should guide Americans in instructing their legislators how to invest their resources!!!

At each stage, a "big" event with Hillary (which would be different each time to capture anew the media's attention) would signal the change-over from one stage to the next. However, after this event takes place, both Hillary and surrogates [within the administration as well as outside of it] would travel around the country to illustrate the primary messages applicable to this developmental time. These visits to successful programs or community-wide efforts would be a way to emphasize and sustain the dispersal of this information.

I urge you to act on this suggestion. I believe it is well suited to the abilities and interests of the First Lady, fits well into a role she is comfortable in assuming, and could be of ENORMOUS benefit to the children and families of this nation. It also emphasizes her own personal role as a mother to Chelsea and a concerned parent!

DESIGNING A STRATEGY:

I suggest putting together a small working group to discuss this strategic approach - or others - regarding Hillary's involvement in children and family issues. Aside from staff of the First Lady, I'd suggest inviting people such as:

Peter Edelman
Dr. Barry Zuckerman
Dr. T. Berry Brazelton
Lisbeth B. Schorr [author of "Within Our Reach"]
Dr. Ed Zigler

I would also like to be included in such a discussion. I feel I bring to the table a high level of understanding about the media's role in this kind of an enterprise, after having covered children and families for Time magazine for nearly a decade.

And, I'd suggest inviting someone such as

Ms. Ann Finucane, an expert in marketing who worked (pro-bono) with Marian Wright Edelman in devising some successful outreach strategies regarding children's issues. She is located in Boston. Her expertise would be in helping us to strategize about how to position Hillary in such a campaign and how to creatively package this idea....

Of one thing I am convinced: By creating this kind of logical, easy-for-the-American-people-to-follow strategy of linking Hillary's educative role to the stages of a child's development, she can be positioned as someone to whom Americans will want to listen when it comes to figuring out what to do to help children. It provides her with a visible stage by which she can respond, as she is often asked to do, in the midst of public policy debates such as the one we are now engaged in about welfare reform.

Liz: I am sending a copy of this memo to you, and asking if you would forward it to The First Lady.

I very much enjoyed the opportunity we had to meet and talk about these concerns. I hope that you will keep me in mind as discussion of these issues - and of how to best approach the dissemination of information continues.

Dear Hillary:

As always, my conversation with you left my mind restless with thought. On Friday, as I dashed about from meeting to meeting and then flew home, your questions and our exchange of ideas kept bouncing around inside of me. Now, it is Saturday morning and I'm home, and as soon as I got up [to a blizzard of snow], I felt as though I was on automatic pilot: a voice inside of me kept saying 'go get your Zigler notes', and so I did.

Back in 1990 - when I was reporting a cover story for Time - "Do We Care About Our Kids: The sorry plight of America's most disadvantaged minority: its children" [I will send by mail a copy of this story], I spent several hours with Ed Zigler talking about children. His insights were extraordinary, and he gave me a copy of what was then in manuscript form - a chapter from a book on the American Family: "The Family Agenda for the 1990s".

Let me simply give you a few quotes which I put in my notes from that manuscript - thoughts which I believe form a present-day basis for a vigorous campaign of public education about the healthy development of children such as we spoke about on Thursday. The observations in this chapter explain the dangers inherent in ignoring in our formation of social policy what we have learned - and are continuing to learn - in our scientific exploration.

> "SHOULD WE CHOOSE TO IGNORE THE CLEAR FINDINGS OF OUR SCIENTISTS AND THE UNDISPUTED FACTS OF FAMILY CHANGE AND RESULTANT FAMILY NEEDS, THE HUMAN CASAULTIES WILL NOT BE SO EASILY IGNORED; THEY WILL SEEK US OUT IN CRIME AND DELINQUENCY, IN DRUG USE, IN UNEMPLOYABILITY, IN SOCIAL WASTE AND PERSONAL DESOLATION."

> "WE HAVE FAILED REPEATEDLY TO UTILIZE THE COLLECTIVE WISDOM OF OUR DEVELOPMENTAL EXPERTS IN FORMULATING ENLIGHTENED SOCIAL POLICY."

The authors quote Uric Bronfenbrenner as saying:

"THE MORE WE LEARN ABOUT THE CONDITIONS THAT FOSTER THE DEVELOPMENT OF HUMAN COMPETENCE AND CHARACTER [health, family, school, child care] THE MORE WE SEE THOSE CONDITIONS ERODED IN OUR SOCIAL ENVIRONMENT."

The theme of this writing is obvious:

"IT IS NOT A QUESTION OF KNOWLEDGE; IT IS A QUESTION OF COMMITMENT AND WILL."

And, Julius Richmond - Director of Health Policy [illegible]icy Research and Education at Harvard - is quoted as saying:

"IN THE LAST THIRTY YEARS OF MONITORING THE INDICATORS OF CHILD WELL-BEING, NEVER HAVE THE INDICATORS LOOKED SO NEGATIVE ACROSS ALL FOUR SYSTEMS ESSENTIAL TO GROWTH OF THE CHILD."

Health
Family
Schools
Child care

The role which is missing today is a visible, public voice connecting these two arenas: WHAT WE KNOW! and WHAT WE DO!

That's the voice I am urging you to be - not in a way which is immediately construed as partisan and thus open to attack, but one which can be viewed as serving the important function of connecting these now-loose threads. And if you set out to do this - as the quotes above demonstrate - you would find yourself surrounded by a chorus of voices who have been trying to deliver this message to political leaders for quite some time.

This strategy of education/policy shaping - using the child's development from 0 to 18 as the ladder of concerns - is more of a long-term approach, but is one which I think could yield short-term gains along the way. I believe, for example, that a conference - moderated by you and broadcast on C-Span - in which experts are assembled to tell the public what the costs are in human (and in monetary terms) of not paying attention to how social environments impact on brain development, etc. would be an attention-grabbing-way to have an immediate and concrete impact on the current political debate.

In terms of addressing your concern about trying to have a constructive and more immediate impact on the debate/policies now being shaped on the Hill - and how to get that information through to those who are not already inclined to receive it - I would propose a roundtable discussion among Senators who are in positions of influence on this topic. You noted your frustration during the push for health care on the hurdles to getting information to those who are disinclined to want to take it in - perhaps a frank discussion of this - with children's issues as the primary focus - would illuminate some of the institutional hurdles and come up with ways to get over them.

Included in that list might be:

Senators Kennedy, Dodd, Daschle
Kassebaum, Jeffords, Hatch

There are obvious advantages to appearing bi-partisan in this outreach effort [though there are also disadvantages in terms of the level of frankness with which the conversation can be conducted]. If you want to concentrate on strategizing with Democrats - then you might substitute Senators such as Patty Murray, Tom Harkin, and Barbara Mikulski and Jeff Bingaman for the Republicans on the list above.

Before closing, let me just reiterate what I said on Thursday -- Children's issues are in the news!! Editors at newspapers are creating "news holes" for articles about what's happening to children. Local TV stations are hiring reporters to do stories about children. Reporters are being asked to concentrate on this as a "beat". This means there is a natural constituency of journalists eager to report on these issues, and most journalists (simply because they are human beings with egos) would like to believe that what they write or broadcast has an impact on informing people but also in shaping what happens to children in this country.

I tend to get to Washington sometime during each month - so I hope we can continue to meet and talk about these issues. I will let Pam know when my next trip is scheduled and, if you think it would be helpful for us to meet at that time, I be delighted to set aside time to do so.

Melissa

Dr. Howard Hiatt
Initiatives for Children
American Academy of Arts and Sciences
136 Irving Street
Cambridge, MA 02138

Dr. Lawrence Katz
National Bureau of Economic Research
1050 Massachusetts Avenue
Cambridge, MA 02138

Dr. Theda Skocpol
Department of Sociology
William James Hall, Room 470
Harvard University
Cambridge, MA 02138

Dr. Janet Currie
Department of Economics
UCLA
405 Hilgard Avenue
Los Angeles, CA 90024

Dr. Frederick Mosteller
Harvard School of Public Health, LL7A
677 Huntington Avenue
Boston, MA 02115

Dr. Frank Furstenberg
Department of Sociology
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3718 Locust Walk
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Dr. Irwin Garfinkel
School of Social Work
Columbia University
622 W. 113th Street
New York, New York 10025

Dr. Rebecca Maynard
Graduate School of Education
University of Pennsylvania
3700 Walnut Street
Philadelphia, PA 19104

Dr. Christopher Jencks
Center of Urban Affairs & Policy Research
Northwestern University
Evanston, IL 60201

Professor Paul Peterson
Department of Government
Littauer Center
Harvard University
Cambridge, MA 02138

To: Liz Bowyer

From: Melissa Ludtke

Re: Follow-up from Feb. 2nd meeting and earlier memo

February 6, 1995

Liz:

I am enclosing with this memo a copy of a Report of the Casey Journalism Center for Children and Families on "Children and Family Journalism: Out from the Shadows, Media Coverage of Children and Family Issues."

Please make sure that The First Lady has an opportunity to thumb through it before you pass it along to Lisa Caputo. [In fact, you might want to contact Cathy Trost at the Casey Center and get another copy. Her phone number is 301-405-2482.] I think it is a valuable document to underscore how engaged some journalists and their publications are in the coverage of these issues. [This would not have been the case even three years ago!]

I am also sending a copy of a Time cover story that I reported on in 1990 - it was in the reporting for this story that I spent time with Ed Zigler at Yale and he gave me a copy of the chapter from which I quoted in my earlier memo. I think this piece - although nearly five years old - is, sadly, just as relevant today. The fundamental issues and questions have not changed, even if the circumstances of kids - particularly the hundreds of thousands more who are living in poverty - have arguably gotten only worse.

That's it for reading material, this time. But I would appreciate if you would also pass on to Hillary the following information: In a phone call this morning with Dr. Howard Hiatt - the man who is in charge of the American Academy of Arts and Science's Initiatives for Children (a memo about which I left with Hillary) - he mentioned that if there is any way in which she can envision the Initiatives Project (and its academic members) being of service to her efforts to educate legislators and the public about the consequences of social policy decisions on children, he would be delighted to convene such a meeting to discuss such assistance.

[As a guide to some of the other social policy academics who are involved in the Initiatives Project, I am enclosing a list of those who met several weeks ago to draft a White Paper for Congressional legislators on the impact of welfare reform measures on children. Please try to ignore the scribbled notes.]

file: ~~Ludtke~~ Ludtke

To: Mrs. Clinton
Fr: Liz Bowyer
Da: 4/29/95
Re: Meeting with Melissa Ludtke

I'll be in Russia doing advance over the next few weeks, so I will miss your meeting with Melissa Ludtke. However, I have listed a few topics that I'm sure she'll want to discuss in the meeting:

National Strategy on Children's Issues

Melissa is very anxious for you to consider the idea of leading a national campaign to educate Americans about child development. Her suggestion -- which is outlined in the attached memo -- is that you spend four or five months highlighting the developmental stages in a child's life, through high-profile events such as forums with child development experts, visits to successful child care programs, etc. Melissa has sent memos to Maggie and Melanne, and is eager to convince you of the merits of this strategy.

Casey Journalism Center Conference

The Casey Journalism Center for Children and Families at the University of Maryland has invited you to participate in a conference entitled "Protecting the Welfare of Children," for print and broadcast journalists who cover child welfare issues. The journalists compete for fellowships to attend the conference, and Melissa has been chosen to participate. She has been working closely with Cathy Trost, the director of the Center, in trying to get this on your schedule (invitation attached). The conference is scheduled for June 11 - 16.

Additional Notes on Melissa

-Melissa has just finished the manuscript of her book on unmarried motherhood in the 1990s. She sent you a copy of the chapter on adolescent mothers.

-A few weeks ago, Melissa was chosen as one of four public policy fellows at Columbia. She'll get to spend a year writing more on children's issues, and plans to move to New York this summer.

-Since your last meeting, Melissa has sent you a number of materials relating to children and violence and child development. I will ask Pam or Nicole to make sure you have the file with the latest materials, including the chapter of Melissa's book.

April 7, 1995

Ms. Hillary Rodham Clinton
Office of the First Lady
West Wing, Second Floor
The White House
Washington, D.C. 20500

Dear Hillary:

Bravo! I hope you and Chelsea are as delighted by the terrific response to your trip as you seemed to be energized and inspired by what you saw and heard. That poem you read from the schoolgirl - about women's roles, circumstances, and the perceptions of them - captured so much of what we all try to articulate about our lives today. It is hard to imagine how you can possibly process all that you were able to experience but I'm certain the trip changes forever the ways both you and Chelsea will see our world through your women's eyes.

During your time in Southeast Asia [and in the days before it], I visited with Liz Bowyer on my trip to Washington. After our meeting [and on her suggestion], I put together a memo for Maggie Williams to give her some idea of what we've been talking about and some of the idea we have been tossing around. I hope she will share this memo [a copy of which I am enclosing for you] with Melanne. Maggie and I have not had a chance to speak about it, though I do have a phone call into her.

Essentially, I make the same point in this memo that I keep emphasizing to you - about how PERFECT the time is for you to take on an educative role about children and families in this country!!!! There is thirst for knowledge about what is happening to kids and families, and knowledge can be transformed into political power if people have a sense of the direct consequences of their inaction and of the ways in which action can be constructive and not solely punitive. What I've suggested to Maggie is that a small working group be convened - first to decide if this is an approach you are interested in taking and how your role in it should be conceived. If you want to move ahead, then the working group - and others - would work to draw up a five-month plan in which you would play an intermittent but crucial role in the strategy.

I am also enclosing some more articles and a short videotape from ABC News which again highlight many of the issues we've been discussing. I hope you have a moment to take a look at them. They enclosures include:

1. The memo I sent to Maggie on our meetings and my follow-up suggestions
2. Articles from the Journal of Public Health on the relationship between a mother's education and her child's propensity for mild retardation
3. ABC News segment [two minutes long] on the study on mild retardation and the decision by CDC to monitor developmental daycare for poor children
4. Section for Carnegie report, "Starting Points" on early brain development + more
5. A section for my manuscript [I don't yet dare call it a book] in which I incorporate material about healthy early development into stories which illustrate how or why it doesn't happen in some children's lives

I hope we can get together again, soon, to talk more about whether the strategy I've proposed, or another one addressing the similar issues, might be something you'd want to get involved with.

All the best,

Melissa

P.S. I just received a letter accepting me as a Casey Fellow for the week-long program in June on the coverage of children and the news. I hope you decided to give the keynote. Not only does it offer a great opportunity but now I have a more selfish reason. It would be great to have you there!!!!

To: First Lady's staff

From: Melissa Ludtke
Public Policy Fellow
Radcliffe College

Re: Follow-up memo to conversations with the First Lady about children/family issues

March 28, 1995

This memo is a compilation of ideas discussed during several meetings I've had with the First Lady, and a suggestion about a strategy I am proposing for her continuing involvement in issues impacting the lives of U.S. children and their families.

During our meeting in February, Hillary and I talked for quite a while about the media's increasing interest in the coverage of children's issues. I shared with her a report done by the Casey Journalism Center for Children and Families; it shows that during the past five years some 35 or so newspapers and news services have added children and /or family beats to their coverage. We talked about how a lot of these reporters now covering children/family issues are eager, because of wanting to develop their beats, to find "serious" news stories to justify and enhance their newspaper's commitment to such coverage.

My point in mentioning this to Hillary was to establish the presence of a growing contingent of reporters and writers, and editors who are all recent converts to the coverage of children. These reporters are not part of the inside-the-beltway press corp but are scattered around the country, trying in various ways to bring news coverage of children and families to readers and viewers. In many instances, given the newness and scope of their assignment, these reporters are not yet knowledgeable about the full range of issues involved in children's lives. Nor do many of them have the kind of opportunity they should to be exposed to the valuable information being unearthed by physicians, social scientists, educators, and neurobiologists about children's needs for healthy development. Instead, many news stories about children arise only out of rancorous political argument about legislation such as welfare reform, in which children become used more as rhetorical devices than as the people whose well-being ought to be the driving force in shaping the debate.

What I proposed to the First Lady - and am now putting on paper for your consideration - is the development of a well-thought-out strategy by which Hillary's vast knowledge about and experience with children's issues, as well as her extraordinary ability to focus public attention and inform public opinion, is utilized in a national effort to educate Americans [and this new crop of reporters and editors] about the immediate, vital need to find common ground in a campaign to improve the lives of all children.

Let me begin by saying what this strategy is NOT.

It is NOT an attempt to have her assume a new and visible policy making role in the administration

It is NOT an attempt to have her spend time up on Capitol Hill visibly appearing to impact legislation

It is NOT an attempt to have her delineate a large governmental solution to problems of children's poverty, etc.

In this strategy, the First Lady's role would be as:

A CONVENER for experts about what is happening in children's lives, to focus a spotlight on the key developmental ingredients which too many children don't have in their lives

A LISTENER to what experts are able to tell us about what each and every child needs to develop into a healthy and productive adult

A GUIDE to take the American people on a voyage of discovery about how some communities have responded well to the needs of children

What I propose is to create a strategy by which the First Lady appears AT THE HUB of an multi-faceted outreach effort to inform and educate the American people about the key developmental issues in children's lives.

How to do this: When we envision a child's life, we think of it as beginning at birth [or before birth] and moving through various developmental stages on its way to adulthood. These developmental stages can be roughtly divided into four parts [for the sake of this discussion]:

Zero to Three: Infant to Toddler
Four to Eight: Preschool to Elementary
Eight to Twelve: Elementary to Pre-Adolescent
Twelve to Seventeen: Adolescence

My suggestion is that intermittently, during a period of four to five months [maybe from July until December 1995], the First Lady would take the American people on a well-coordinated journey of discovery about what constitutes healthy development for a child in each of these stages. And there is no lack of medical and education experts, such as T. Berry Brazelton [to name an obvious one] who would be delighted to work alongside the First Lady to bring what they know about this to the American people.

For example, in the initial section, when we focus on the Zero to Three years, Hillary - AT THE HUB of this effort could highlight a wealth of fascinating and important new findings about what happens in an infant/toddler's brain. Now that scientists can, for the first time, actually peer inside of a child's developing brain and see the formation of synapses which determine his/her future intellectual growth, they are also finding strong links between what happens [or fails to happen] inside the brain with the environmental stimulation and nourishment a baby receives.

The Carnegie Corporation's report "Starting Points" drew attention to the importance of these new findings in 1994 but neither that report nor this information has been widely disseminated or stressed to legislators who are, for the most part, ignorant about such findings. Also, I gave Hillary [and Liz Bowyer] a five-part, Pulitzer-award winning Chicago Tribune series from 1993 which was about brain development. In these articles the author noted that during the past decade scientists have learned more about the human brain than in all previous history. Pioneering studies, the reporter tells us, show the IQs of children born into poverty can be significantly raised by exposure to toys, words, proper parenting and other stimuli. It is important that what these scientists are learning be also learned by the American people who must make decisions about how we, as a society, invest our resources.

By bringing together a group of articulate scientists whose work is on the cutting edge of this research, the First Lady would inject into this on-going partisan debate the kind of solid information [and persuasive and powerful visual images of brain development] which is woefully lacking. Present also could be early childhood development experts from the worlds of psychology and education to address from their perspectives what can happen to divert healthy development in a child during these years.

I have discussed with Hillary the idea of convening such a group - not unlike the President's pre-inaugural economic summit in Little Rock - getting C-Span to televise it, and issuing findings from it as a public service to the American people. Dr. Barry Zuckerman, a member of

the National Commission on Children, a pediatrician and researcher and head of Boston City Hospital's division of Developmental and Behavioral Pediatrics, told me that this information about early brain development and the visual evidence he's able to show people are the most powerful and persuasive tools he's ever found in convincing people of the need to pay attention.

Each of these four developmental stages offers fertile ground for gathering new and important findings regarding children and families, and highlighting them for both reporters and the public who are astonishingly ill-informed. [I won't detail each one of them now, but suffice it to say there is more than enough material for the First Lady to spotlight - such as, in the pre-adolescent and adolescent stages, her concern about drawing attention to the impact of violence in the lives of children.] And while this strategy keeps the First Lady away from explicitly entering the fray of public policy debate, her ability to place a frame of public policy around this information and inform basic principles which should guide Americans in instructing their legislators how to invest their resources!!!

At each stage, a "big" event with Hillary (which would be different each time to capture anew the media's attention) would signal the change-over from one stage to the next. However, after this event takes place, both Hillary and surrogates [within the administration as well as outside of it] would travel around the country to illustrate the primary messages applicable to this developmental time. These visits to successful programs or community-wide efforts would be a way to emphasize and sustain the dispersal of this information.

I urge you to act on this suggestion. I believe it is well suited to the abilities and interests of the First Lady, fits well into a role she is comfortable in assuming, and could be of ENORMOUS benefit to the children and families of this nation. It also emphasizes her own personal role as a mother to Chelsea and a concerned parent!

DESIGNING A STRATEGY:

I suggest putting together a small working group to discuss this strategic approach - or others - regarding Hillary's involvement in children and family issues. Aside from staff of the First Lady, I'd suggest inviting people such as:

Peter Edelman
Dr. Barry Zuckerman
Dr. T. Berry Brazelton
Lisbeth B. Schorr [author of "Within Our Reach"]
Dr. Ed Zigler

I would also like to be included in such a discussion. I feel I bring to the table a high level of understanding about the media's role in this kind of an enterprise, after having covered children and families for Time magazine for nearly a decade.

And, I'd suggest inviting someone such as

> Ms. Ann Finucane, an expert in marketing who worked (pro-bono) with Marian Wright Edelman in devising some successful outreach strategies regarding children's issues. She is located in Boston. Her expertise would be in helping us to strategize about how to position Hillary in such a campaign and how to creatively package this idea....

Of one thing I am convinced: By creating this kind of logical, easy-for-the-American-people-to-follow strategy of linking Hillary's educative role to the stages of a child's development, she can be positioned as someone to whom Americans will want to listen when it comes to figuring out what to do to help children. It provides her with a visible stage by which she can respond, as she is often asked to do, in the midst of public policy debates such as the one we are now engaged in about welfare reform.

Liz: I am sending a copy of this memo to you, and asking if you would forward it to The First Lady.

I very much enjoyed the opportunity we had to meet and talk about these concerns. I hope that you will keep me in mind as discussion of these issues - and of how to best approach the dissemination of information continues.

Dear Hillary:

As always, my conversation with you left my mind restless with thought. On Friday, as I dashed about from meeting to meeting and then flew home, your questions and our exchange of ideas kept bouncing around inside of me. Now, it is Saturday morning and I'm home, and as soon as I got up [to a blizzard of snow], I felt as though I was on automatic pilot: a voice inside of me kept saying 'go get your Zigler notes', and so I did.

Back in 1990 - when I was reporting a cover story for Time - "Do We Care About Our Kids: The sorry plight of America's most disadvantaged minority: its children" [I will send by mail a copy of this story], I spent several hours with Ed Zigler talking about children. His insights were extraordinary, and he gave me a copy of what was then in manuscript form - a chapter from a book on the American Family: "The Family Agenda for the 1990s".

Let me simply give you a few quotes which I put in my notes from that manuscript - thoughts which I believe form a present-day basis for a vigorous campaign of public education about the healthy development of children such as we spoke about on Thursday. The observations in this chapter explain the dangers inherent in ignoring in our formation of social policy what we have learned - and are continuing to learn - in our scientific exploration.

> "SHOULD WE CHOOSE TO IGNORE THE CLEAR FINDINGS OF OUR SCIENTISTS AND THE UNDISPUTED FACTS OF FAMILY CHANGE AND RESULTANT FAMILY NEEDS, THE HUMAN CASAULTIES WILL NOT BE SO EASILY IGNORED; THEY WILL SEEK US OUT IN CRIME AND DELINQUENCY, IN DRUG USE, IN UNEMPLOYABILITY, IN SOCIAL WASTE AND PERSONAL DESOLATION."

> "WE HAVE FAILED REPRATEDLY TO UTILIZE THE COLLECTIVE WISDOM OF OUR DEVELOPMENTAL EXPERTS IN FORMULATING ENLIGHTENED SOCIAL POLICY."

The authors quote Urie Bronfenbrenner as saying:

"THE MORE WE LEARN ABOUT THE CONDITIONS THAT FOSTER THE DEVELOPMENT OF HUMAN COMPETENCE AND CHARACTER [health, family, school, child care] THE MORE WE SEE THOSE CONDITIONS ERODED IN OUR SOCIAL ENVIRONMENT."

The theme of this writing is obvious:

"IT IS NOT A QUESTION OF KNOWLEDGE; IT IS A QUESTION OF COMMITMENT AND WILL."

And, Julius Richmond - Director of Health Policy [illegible]cy Research and Education at Harvard - is quoted as saying:

"IN THE LAST THIRTY YEARS OF MONITORING THE INDICATORS OF CHILD WELL-BEING, NEVER HAVE THE INDICATORS LOOKED SO NEGATIVE ACROSS ALL FOUR SYSTEMS ESSENTIAL TO GROWTH OF THE CHILD."

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This strategy of education/policy shaping - using the child's development from 0 to 18 as the ladder of concerns - is more of a long-term approach, but is one which I think could yield short-term gains along the way. I believe, for example, that a conference - moderated by you and broadcast on C-Span - in which experts are assembled to tell the public what the costs are in human (and in monetary terms) of not paying attention to how social environments impact on brain development, etc. would be an attention-grabbing-way to have an immediate and concrete impact on the current political debate.

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Included in that list might be:

Senators Kennedy, Dodd, Daschle
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Before closing, let me just reiterate what I said on Thursday -- Children's issues are in the news!! Editors at newspapers are creating "news holes" for articles about what's happening to children. Local TV stations are hiring reporters to do stories about children. Reporters are being asked to concentrate on this as a "beat". This means there is a natural constituency of journalists eager to report on these issues, and most journalists (simply because they are human beings with egos) would like to believe that what they write or broadcast has an impact on informing people but also in shaping what happens to children in this country.

I tend to get to Washington sometime during each month - so I hope we can continue to meet and talk about these issues. I will let Pam know when my next trip is scheduled and, if you think it would be helpful for us to meet at that time, I be delighted to set aside time to do so.

Melissa

Casey Journalism Center for Children and Families

Cathy Trost, Director

Lisa Caputo
Press Secretary
Office of the First Lady
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

January 17, 1995

Dear Ms. Caputo:

I am writing in the hopes of arranging an interview with Hillary Rodham Clinton at the White House with 30 print and broadcast journalists who cover child welfare issues. These journalists will be attending the Casey Journalism Center's week-long conference on "Protecting the Welfare of Children" at the University of Maryland, June 11-16, 1995.

The journalists, who compete for fellowships to attend the conference, have substantial backgrounds in covering childrens' issues and their work has wide impact. Past conferences have included journalists from the *Washington Post, Congressional Quarterly, ABC World News Tonight "American Agenda." USA Today, U.S. News & World Report, Education Week, Chicago Tribune, Boston Globe, San Francisco Examiner, Philadelphia Inquirer and Baltimore Sun.* Mrs. Clinton's remarks would receive even wider exposure through a summary of the conference which is published in the national monthly magazine *American Journalism Review.*

Journalists attending these intensive conferences participate with a range of experts to better understand the complex forces which shape children's lives today. Past speakers have included Attorney General Janet Reno, Children's Defense Fund president Marian Wright Edelman and Baltimore Mayor Kurt Schmoke. We are a journalism center funded by the Annie E. Casey Foundation and based at the University of Maryland, aimed at enhancing the quality of reporting about the issues and institutions affecting disadvantaged children and their families.

Key themes which we will explore in the conference are the connecting problems which challenge children and families today, and the roles that government, communities and families play in protecting and supporting children and families. The core focus of the conference will be exploring the causes of increasing poverty among the young, and the debate over how we as a country can create more economic and cultural stability for vulnerable children and their families. The journalists will be spending the week engaged in discussions about the competing proposals for welfare reform, teen pregnancy, the role of fathers and the changing economic structure and ways to strengthen families.

Would it be possible to arrange such a session at any time during the weekday portion of our conference, Monday through Friday, June 12-16? I will call your office next week to follow up.

Sincerely,

Cathy Trost

Cathy Trost, Director

College of Journalism, University of Maryland, College Park, MD 20742-7111
Phone (301) 405-2482 ■ FAX (301) 314-1516

Casey Journalism Center
for Children and Families

Cathy Trost, Director

February 20, 1995

Dear Melissa:

Here's the letter which was sent to Lisa Caputo in Mrs. Clinton's press office in mid-January. As I mentioned on the phone, I spoke to Karen Finniak, a deputy press secretary on Feb. 7, who said she was handling the request and had no answer yet.

I can't think of a better person to keynote this conference than the First Lady. I did not extend an invitation to be keynote speaker because I thought that would be a more difficult proposition than just bringing the reporters to the White House. If you think Mrs. Clinton might be interested, please extend the invitation personally on behalf of the Casey Center. The keynote kicks off the opening night of the conference, which is Sunday, June 11. We usually open with a 6 p.m. reception and 7 p.m. dinner, followed by the keynote address and Q and A with the journalists. These are on-the-record sessions which are transcribed for summary and publication. When Attorney General Janet Reno was the keynote speaker in 1993, we had the 30 journalists and about 60 members of the university community attending the dinner, including the president and provost of the University of Maryland.

If her office thinks it would be more workable to bring the journalists to the White House, however, we will certainly do that. I had left the dates wide open, offering to bring them any time during the course of the conference, Monday through Friday, June 12-16. I'm starting to schedule panels during those days, assuming that if we get the go-ahead we'll just rearrange our schedule. At this point, Wednesday afternoon, June 14 would be the best fit on our schedule, if that gives any assistance. We were going to try to spend Wednesday morning on the Hill, getting briefings from Congressional members and staff. But nothing is locked in yet.

Thank you so much for helping with this. I do believe Mrs. Clinton is a voice that should be heard by serious journalists covering child welfare issues, and this would be a very good forum. I'll wait eagerly to hear from you.

Best regards,

Cathy Trost

Cathy Trost

College of Journalism, University of Maryland, College Park, MD 20742-7111
Phone (301) 405-2482 ■ FAX (301) 314-1516

DRAFT AGENDA
"CHILDREN'S POVERTY AND CHILDREN'S LEARNING"
MARCH 22 AND 23, 1995

Wednesday, March 22, 1995, 7 p.m.

Dinner and Conference Opening

Introduction by Marian Wright Edelman and Howard Hiatt

Comments by Robert Solow

Remarks by Luther Williams, Assistant Director, Directorate of Education and Human Resources, National Science Foundation

Response by Administration Representatives

Response by Alex Kotlowitz

Thursday, March 23, 1995

8:30 a.m. to 10:45 a.m. Pathways from Income to Learning

Overview by Lawrence Aber

"Stress, Depression, Family Process" -- Vonnie McLoyd

"Health and Nutrition Paths from Poverty to Learning" -- Lorraine Klerman

Panel Response by Christopher Jencks and others

In-Room Break

11 a.m. to 1 p.m. The Size of Child Poverty Effects on Learning

"Poverty and Educational Attainment" -- Robert Haveman and Barbara Wolfe

"Long-Term Poverty as Predictor of Achievement Test Scores" -- Sanders Korenman and Jane Miller

"Impact of Income on School Dropout Rates" -- Susan Mayer

Panel Response

1-2 p.m. Lunch

2:15 to 4 p.m. Labor Market Implications

"Education and Earnings" -- Thomas Kane

"Measuring Indirect Productivity Effects of Poverty, via Education" -- TBA

"Labor Market Effects of Poverty, Measured Directly" -- Mary Corcoran

Panel Response by Lawrence Katz and others

4 to 5 p.m. Reflections/Identifying Future Research Needs

5 p.m. Cash Bar Reception

PHOTOCOPY
HRC HANDWRITING

To: **Mrs. Clinton**
Fr: **Liz Bowyer**
Da: **2/15/95**
Re: **Materials from Melissa Ludkte**

Attached is a TIME cover story that Melissa helped write in 1990 entitled "Do We Care About Our Kids?." Melissa spent a lot of time talking with Ed Zigler at Yale about the story, and she thought you might be interested in reading it. She also thought you might want to look through the Casey Center's study on media coverage of children and family issues.

Melissa asked if I would pass on one more message to you -- Dr. Howard Hiatt, the head of the American Academy of Arts and Science's Initiatives for Children, wants to become involved in helping to educate legislators and the public about the consequences of social policy decisions on children. If there is any way that you can envision the Initiatives Project being of service, Dr. Hiatt and the project members would like to help.

Liz - Have you talked w/ Dr. Hiatt? If not please do so to discuss what he could do. FAX him cc of my Child Welfare speech. Ask for ideas about what points I could be making. Thanks.

H

To: **Mrs. Clinton**
Fr: **Liz Bowyer**
Da: **2/15/95**
Re: **Materials from Melissa Ludkte**

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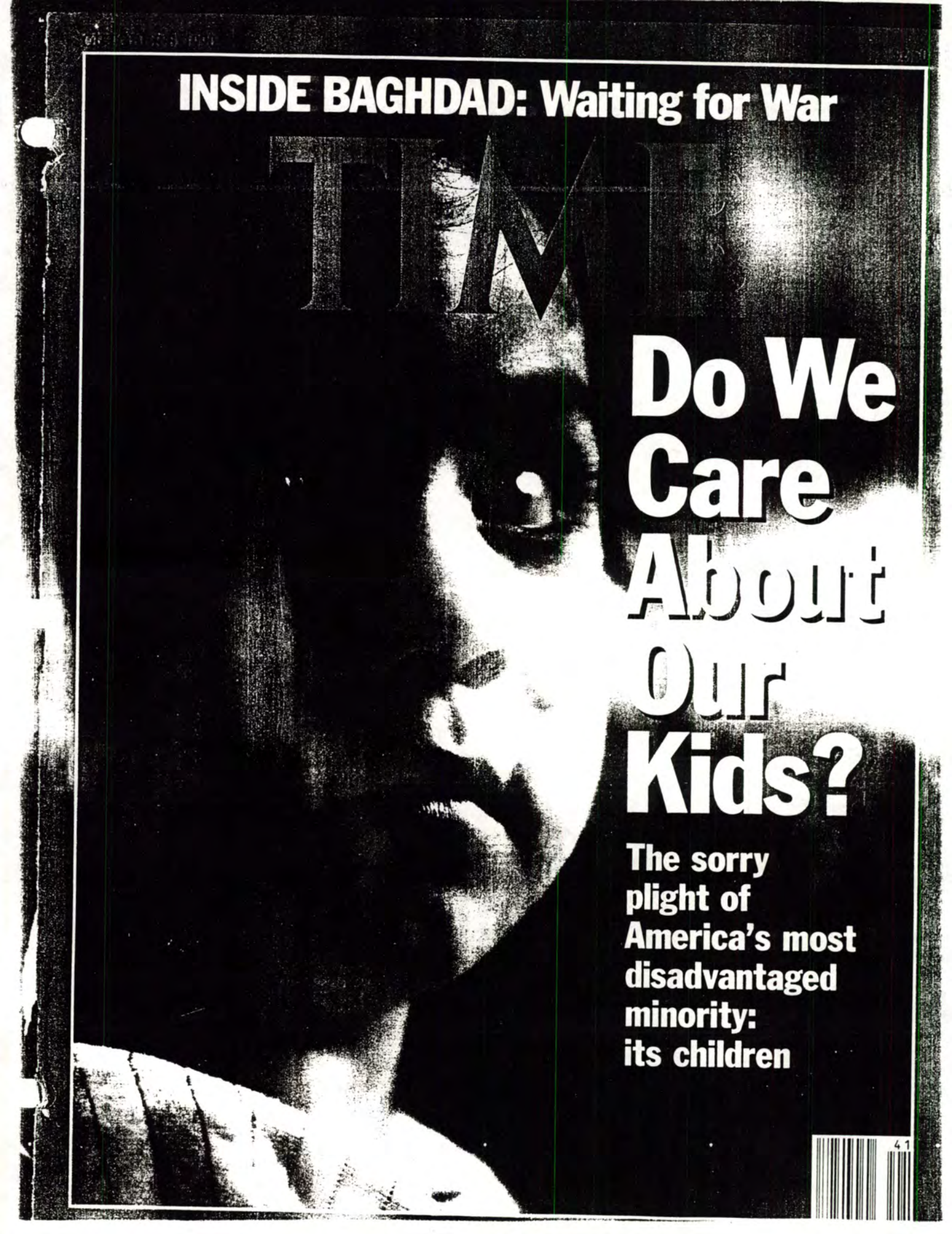
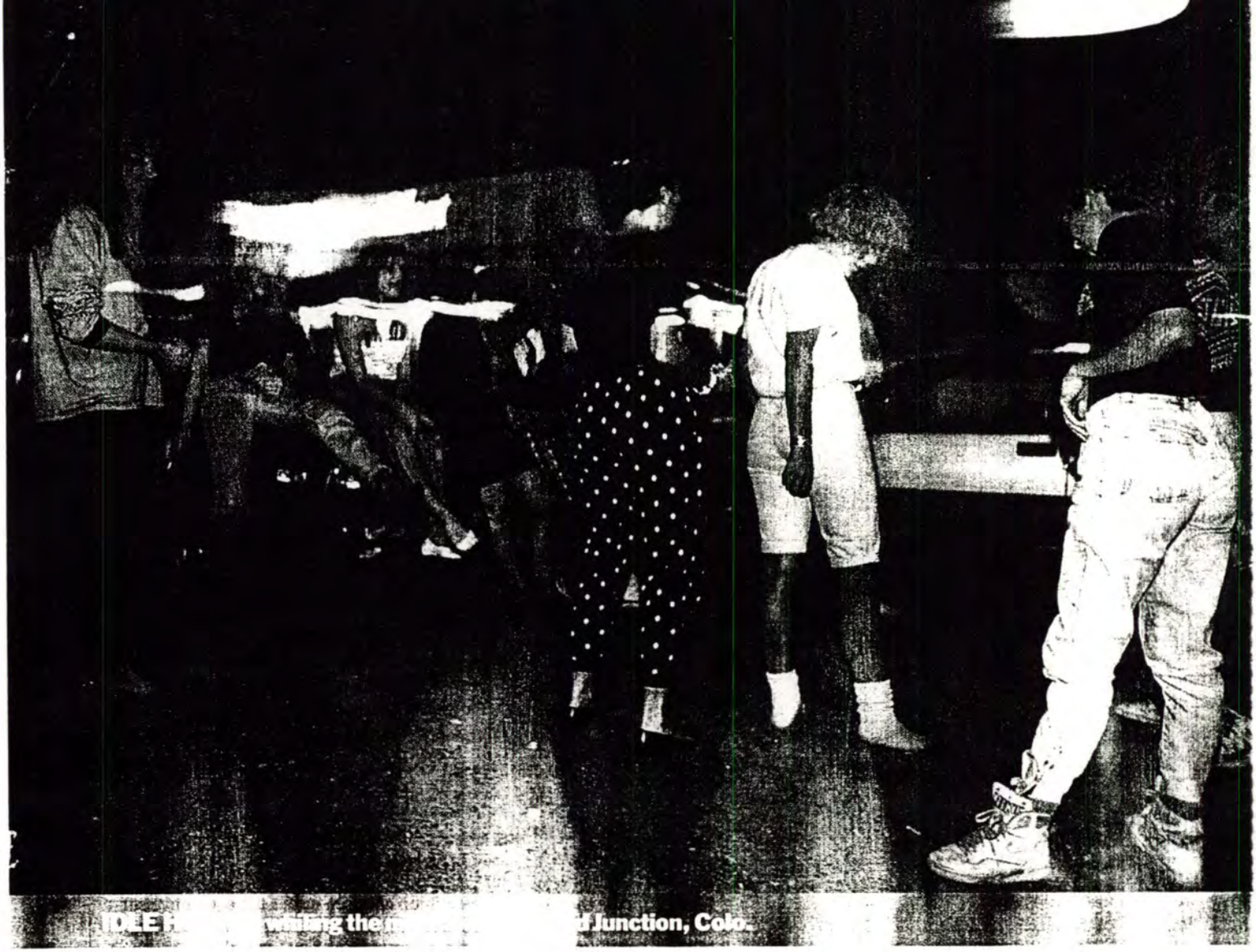
INSIDE BAGHDAD: Waiting for War

TIME

Do We Care About Our Kids?

The sorry plight of America's most disadvantaged minority: its children





Shameful Bequests to The Next Generation

America's legacy to its young people includes bad schools, poor health care, deadly addictions, crushing debts—and utter indifference

By NANCY GIBBS

George Bush knows how to talk about children. With a sure sense of childhood's mythology, of skinned knees and candy apples and first bicycles, he campaigned for office in a swarm of jolly grandchildren and promised justice for all. In this year's State of the Union address, he mentioned families and "kids" more than 30 times—the electronic equivalent of kissing babies on the village green. "To the children out there tonight," he declared as he built to his finale, "with you rests our hope, all that America will mean in the years ahead. Fix your vision on a new century—your century, on dreams you cannot see, on the destiny that is yours and yours alone."

Forget the next century. Just consider for a moment a single day's worth of destiny for American children. Every eight seconds of the school day, a child drops out. Every 26 seconds, a child runs away from home. Every 47 seconds, a child is abused or neglected. Every 67 seconds, a teenager has a baby. Every seven minutes, a child is arrested for a drug offense. Every 36 minutes, a child is killed or injured by a gun. Every day 135,000 children bring their guns to school.

Even children from the most comfort-

able surroundings are at risk. A nation filled with loving parents has somehow come to tolerate crumbling schools and a health-care system that caters to the rich and the elderly rather than to the young. A growing number of parents with preschool children are in the workplace, but there is still no adequate system of child care, and parental leaves are hard to come by. Mothers and fathers worry about the toxic residue left from too much television, too many ghastly movies, too many violent video games, too little discipline. They wonder how to raise children who are strong and imaginative and loving. They worry about the possibility that their children will grow wild and distant and angry. Perhaps they fear most that they will get the children they deserve. "Children who go unheeded," warns Harvard psychiatrist Robert Coles, giving voice to a parent's guilty nightmare, "are children who are going to turn on the world that neglected them."

And that anger will come when today's children are old enough to realize how relentlessly their needs were ignored. They will see that their parents and grandparents have left them enormous debts and a fouled environment. They will recognize that their exceptionally prosperous, peaceful, lucky predecessors, living out the end of the millennium, were not willing to make the investments necessary to ensure that the generation to follow could enjoy the same blessings.

The natural case for taking better care of children would be made on moral grounds alone. A society cannot sacrifice its most vulnerable citizens without eroding its sense of community and making a lie of its principles. But having been left behind by a decade of political shortcuts, child advocates have adopted a more practical strategy. "If compassion were not enough to encourage our attention to the plight of our children," declares New York Governor Mario Cuomo, "self-interest should be." Marian Wright Edelman, the crusading founder of the Children's Defense Fund, goes further. "The inattention to children by our society," she warns, "poses a greater threat to our safety, harmony and productivity than any external enemy."

Spending on children, any economist can prove, is a bargain. A nation can spend money either for better schools or for larger jails. It can feed babies or pay forever for the consequences of starving a child's brain when it is trying to grow. One dollar spent on prenatal care for pregnant women can save more than $3 on medical care during an infant's first year, and $10 down the line. A year of preschool costs an average $3,000 per child; a year in prison amounts to $16,500.

But somehow, neither wisdom nor decency, nor even economics, has prevailed with those who make policy in the state houses, the Congress or the White House. "We are hypocrites," charges Senator John D. ("Jay") Rockefeller IV, who is chairman of the National Commission on Children. "We say we love our children, yet they have become the poorest group in America." Nearly a quarter of all children under six live in households that are struggling below the official poverty line—$12,675 a year for a family of four.

In some cases the abandonment of children begins before they are even born. America's infant mortality rate has leveled off at 9.7 deaths per 1,000 births, worse than 17 other developed countries. In the District of Columbia, the rate tops 23 per 1,000, worse than Jamaica or Costa Rica. Fully 250,000 babies are born seriously underweight each year. To keep these infants in intensive care costs about $3,000 a day, and they are two to three times more likely to be blind, deaf or mentally retarded. On the other hand, regular checkups and monitoring of a pregnant woman can cost as little as $500 and greatly increase the chances that she will give birth to a healthy baby.

CYNTHIA JOHNSON

CRUEL BEGINNING: born with the AIDS virus in Washington

Every bit as important as prenatal care is nutrition for the child, both before and after birth. "Of all the dumb ways of saving money, not feeding pregnant women and kids is the dumbest," says Dr. Jean Mayer, one of the world's leading experts on nutrition and president of Tufts University. During the first year of life, a child's brain grows to two-thirds its final size. If a baby is denied good, healthy food during this critical period, he will need intensive nutritional and developmental therapies to repair the damage. "Kids' brains can't wait for Dad to get a new job," says Dr. Deborah Frank, director of growth and development at Boston City Hospital, "or for Congress to come back from recess."

Congress understood the obvious benefits of promoting infant nutrition in the 1970s, when it launched the Special Supplemental Food Program for Women, Infants and Children. WIC provides women with vouchers to buy infant formula, cheese, fruit juice, cereals, milk and other wholesome foods, besides offering nutrition classes and medical care. It costs about $30 a month to supply a mother with vouchers—yet government funds are so tight that only 59% of women and infants who qualify for WIC receive the benefits. "A power breakfast for two businessmen is one woman's WIC package for a month," says Dr. Frank. "Why can't public-policy makers see the connection between bad infant nutrition, which is cheap and easy to fix, and developmental problems, which are expensive and often difficult to fix?"

The theme of prevention applies just as forcefully to medicine. This year the U.S. will spend about $660 billion, or 12% of its GNP, on medical services, but only a tiny fraction of that will go toward prevention. For children the most basic requirement is inoculation, the surest way to spare a child—and the health-care system—the ravages of tuberculosis, polio, measles and whooping cough. During the first 20 years after the discovery of the measles vaccine, public-health experts estimate, more than $5 billion was saved in medical costs, not to mention countless lives. And yet these days in California, the nation's richest state, only half of California's two-year-olds are fully immunized. Dallas reported more than 2,400 measles cases from last December through July, eight of them fatal, including one child who lived within six blocks of an immunization clinic.

Between 1978 and 1987, spending on programs for the elderly rose 52%; spending on children dropped 4%

Even parents who recognize the importance of preventive care are having a harder time affording it for their children. Most Americans over age 65 are covered by Medicare, the federal health-insurance plan under

JEFFERY FOSS DAVIS

RAISING HOPES: Des Moines's Sunburst Lady works with students

Which the elderly—rich or poor—are eligible for benefits. Children's health programs, in contrast, are subject to annual congressional whims and budget cutting. Fewer and fewer employers, even of well-paid professionals, provide health benefits that cover children for routine medical needs. This means that health costs are the responsibility of individual parents, who make do as best they can, often at considerable sacrifice.

Some states and community groups are trying to help. Two years ago, Minnesota pioneered the Children's Health Plan to provide primary preventive care for children. The plan costs the state about $180 per child, but parents pay only $25: in the end everyone saves. Schools in Independence, Mo., established a health-care package to provide drug and alcohol treatment and counseling services for every child in the district. Cost to parents: $10 per child. In Pittsburgh 12,000 children have received free health care through a program crafted by churches, civic groups, Blue Cross and Blue Shield.

But too many kids are denied such care, and that starts a chain reaction. "You can't educate a child unless all systems are go, i.e., brain cells, eyes, ears, etc.," says Rae Grad, executive director of the National Commission to Prevent Infant Mortality. A national survey in 1988 found that two-thirds of teachers reported "poor health" among children to be a learning problem. This is why Head Start, the model federal program providing quality preschool for poor children, also includes annual medical and dental screenings. But once again the money is not there: only about 20% of eligible children are fully served by the program.

Head Start and similar preschool strategies improve academic performance in the early grades and pay vast dividends over time. President Bush has promised enough funding to put every needy child in Head Start, which Congress says will require a fivefold increase by 1994 from the present $1.55 billion a year. Both the House and the Senate have approved higher funding levels, and lawmakers will soon meet to reconcile differences between the two bills. But as the deficit mounts, the peace dividend sinks into the Persian Gulf and the savings and loan crisis chews into basic budget items, politicians may have a hard time approving funding increases for a constituency that does not vote. Senator Orrin Hatch of Utah, a proponent of costly child-care legislation, says the outcome of the budget negotiations is "going to be terrible for kids."

In France, Belgium, Italy and Denmark, at least 75% of children ages 3 to 5 are in some form of state-funded preschool program

Likewise, American society has, in the past generation, abandoned its commitment to providing a world-class system of secondary education. Education Secretary Lauro Cavazos himself calls student performance "dreadfully inadequate." From both the inner cities and the affluent suburbs comes a drumbeat of stories about tin-pot principals who cannot be fired, beleaguered teachers with unmanageable workloads and illiterate graduates with abysmal test scores. If they can possibly afford to, parents choose private or parochial schools, leaving the desperate or destitute in the worst public schools. Teachers, meanwhile, are aware that they are often the most powerful influences in a child's life—and that their job pays less in a year than a linebacker or rock star can earn in a week.

Across the board, people who deal with children are more ill-paid, unregulated and less respected than other professionals. Among physicians, pediatricians' income ranks near the bottom. In Michigan preschool teachers with five years' experience earn $12,000, and prison guards with the same amount of seniority earn almost $30,000. U.S. airline pilots are vigilantly trained, screened and monitored; schoolbus drivers are not. "My hairdresser needs 1,500 hours of schooling, takes a written and practical test and is relicensed every year," says Flora Patterson, a foster parent in San Gabriel, Calif. "For foster parents in Los Angeles County there is no mandated training, yet we are dealing with life and death." The typical foster parent there earns about 80¢ an hour.

Worst of all is the status of America's surrogate parents: the babysitters and day-care workers who have become essential to the functioning of the modern family. In the absence of anything like a national child-care policy, parents are left to improvise. The rich search for trained, qualified care givers and pay them whatever it takes to keep them. But for the vast majority, child care is a game of Russian roulette: rotating nannies, unlicensed home care, unregulated nurseries that leave parents wondering constantly: Is my child really safe? "Finding child care is such a gigantic crapshoot," says Edward Zigler, director of Yale's Bush Center in Child Development and Social Policy. "If you are lucky, you are home free. But if you are unlucky, well, there are some real horror stories out there of kids being tied into cribs."

The U.S. economy has long been geared to two-income families; many fam-

ilies could not afford a middle-class lifestyle without both parents working. The real median income of parents under age 30 fell more than 24% from 1973 to 1987, according to a study by the Children's Defense Fund and Northeastern University. But social programs rarely reflect those economic realities. Growing financial pressure all too often translates into fewer doctors' visits, more stress and less time spent together as a family. Between 1950 and 1989, the divorce rate doubled: 1.16 million couples split up each year. That makes the need for reliable support services for children all the greater.

In place of responses came rhetoric: a 1986 Administration report on the family titled "Preserving America's Future" called for a return to "traditional values," parental support of children and "lovingly packed lunch boxes." Time and again, Washington has failed to address the needs of working parents—most recently in June, when President Bush vetoed the family-leave bill on the ground that it was too burdensome for business. The bill would have allowed a worker to take up to 12 weeks a year of unpaid leave to care for a newborn, an adopted child or a sick family member.

That is abysmal compared with what other industrialized nations allow. Salaried women in France can take up to 28 weeks of unpaid maternity leave or up to 20 weeks of adoption leave, though they are less likely to need it since day care, health care and early education are widely available in that country. In France, as well as in Belgium, Italy and Denmark, at least 75% of children ages 3 to 5 are in some form of state-funded preschool programs. In Japan both the government and most companies offer monthly subsidies to parents with children. In Germany parents may deduct the cost of child care from their taxes. "Under our tax laws," observes Congresswoman Pat Schroeder of Colorado, "a businesswoman can deduct a new Persian rug for her office but can't deduct most of her costs for child care. The deduction for a Thoroughbred horse is greater than that for children."

If the troubles children face were all born of economic pressure on the family, then wealthy children should emerge unscathed. Yet the problems confronting affluent children are also profound and insidious. Parents who do not spend time with their children often spend money instead. "We supply kids with things in the absence of family," says Barbara MacPhee, a school administrator in New Orleans. "We used to build dreams for them, but now we buy them Nintendo toys and

PETER POULIDES

Reebok sneakers." In the absence of parental guidance and affirmation, children are left to soak in whatever example their environment sets. A childhood spent in a shopping mall raises consumerism to a varsity sport; time spent in front of a television requires no more imagination than it takes to change channels.

At Winchester High School in a cozy Boston suburb, clinical social worker Michele Diamond hears it all: the drug use, the alcohol, the eating disorders, the suicide attempts by children who are viewed as privileged. "Kids are left alone a lot to cope," she says, "and they sense less support from their families." Pressured to succeed, to "fit in," to be accepted by top colleges, the students handle their stress however they can. Some just dissolve their problems in a glass. In nearby Belmont, a juvenile officer finds that parents shrug off the danger. When their kids are caught drinking, he notes, "they say, 'Thank God it isn't cocaine. It's alcohol. We can handle that.' "

All too often it *is* cocaine, the poisonous solace common to the golf club and the ghetto. It is not only the violence of the drug culture that threatens children; it is also the lure of the easy money that turns 11-year-olds into drug runners. "Alienated is too weak a word to describe these kids," says Edward Loughran, a 10-year veteran of the juvenile-justice system in Massachusetts. "They don't value their lives or anyone else's life. Their values system says, 'I am here alone. I don't care what society says.' A lot of these kids are dying young deaths and don't care because they don't feel there is any reason to aspire to anything else."

Violence in the neighborhood is bad enough. Violence in the home is devastating. Reports of child abuse have soared from 600,000 in 1979 to 2.4 million in 1989, a searing testimony to the enduring role of children as the easiest victims. In New York City, half of all abuse reports are repeat cases of children who have had to be rescued before, only to be returned to an abusive home.

When two-year-old "Rebecca" accidentally soiled her underwear, her mother and the mother's boyfriend were not pleased. So they heated up some cooking oil, held Rebecca down and poured it over her. Then they waited a week or so before Rebecca's mother, unable to stand the stench of the child's legs, which were rotting from gangrene, took her to the hospital. After a month's stay that saved her legs, Rebecca was able to move to a foster home. From there she went to live with her paternal grandmother, who had plenty of room: all four of her sons were in state prison.

Around the country there are hundreds of thousands of other children who scream for help from overburdened teachers, understaffed social service agencies, crowded courts and a gridlocked foster-care system. To dismiss child abuse as a personal, private tragedy misses the larger point entirely. If children are not protected from their abusers, then

the public will one day have to be protected from the children. To walk through death row in any prison is to learn what child abuse can lead to when it ripens. According to attorneys who have represented them, roughly 4 out of 5 death row inmates were abused as children.

A reordering of priorities toward protecting children would include far higher funding and staffing of Child Protective Services, the organization that investigates charges of abuse and can move to rescue children before the damage is irreparable. But even that would do little good if there is no place to put them. No solution will be possible without an overhaul of the foster-care system, which in many cities is on the verge of collapse. All too often, children are separated from siblings and shuttled from group homes to relatives to foster families, with no sense of the safety, security or stability they need to succeed in school and elsewhere. "If we don't have money for adequate care," says Ruth Massinga, a member of the National Commission on Children, "removing children from their homes is just another devastation."

Failure to make treatment available to drug addicts who seek it will ensure yet another generation of addicted babies and battered kids. In Los Angeles the number of drug-exposed babies entering the foster-care system rose 453% between 1984 and 1987. A survey of states found that drugs are involved in more than 2 out of 3 child abuse and neglect cases. Children born into a family of addicts are left with impossible choices: a life with the abusers they know, or a life at the mercy of a system filled with strangers—lawyers, judges, social workers, foster parents.

It is a common mistake to assume that all abuse is physical. The scars of other forms of abuse—like unrelenting verbal cruelty—can be just as apparent when children grow older, unloved and self-hating. "You can tell kids you love 'em," says April, a runaway in Hollywood. "But that's not the same as showing them. Broken promises is really what tears your heart apart." For April there is not much difference between insult and injury. "Beating kids will hurt kids. Sexual abuse will hurt a kid. But verbal abuse is the worst. I've had all three. If you're not strong enough as a person, and they've been telling you this all your life, that you can never amount to anything, you are going to believe it."

There have always been children who are survivors, who overcome the odds and find some adult—a teacher, a grandparent, a priest—who can provide the anchors the family could not. Touré Diggs, 18, grew up in a rough neighborhood of New Haven, Conn., and is now enrolled at Fairleigh Dickinson University. Since his parents separated three years ago, Touré has tried to help raise his brother Landis, who is 7. In the end Touré knows he is competing with the lure of the street for Landis' soul. "You got to start so young," Touré says. "It's like a game. Whoever gets to the kids first, that's how they are going to turn out."

BIG BROTHER: Touré Diggs with Landis in New Haven, Conn.

CYNTHIA JOHNSON

Schools in particular have come to take that role very seriously, which accounts for the debate over how to teach values and self-discipline to a generation whose boundaries have been loosely drawn. But other institutions are slowly waking up to the implications of writing off an entire generation. The business community, in particular, wonders where it will find a trained, literate, motivated work force in the 21st century. The Business Roundtable, with representatives from the largest 200 companies, has made support for education its highest priority in the '90s. In Dallas, Texas Instruments helps fund the local Head Start program. Eventually, more and more companies may make parental leave a standard benefit, regardless of the messages coming from Washington.

In Des Moines business leaders are sponsoring a program called Smoother Sailing, which sends counselors like "Sunburst Lady" Toni Johansen into the city's elementary schools. National studies have shown that such support helps improve confidence, discipline and attitudes about school. With the extra funding, the city has been able to provide one guidance counselor for every 250 students, in contrast to a national average of one for 850.

But there will be no real progress, no genuine hope for America's children until the sense of urgency forces a reconsideration of values in every home, up to and including the White House. Polls suggest the will is there: 60% of Americans believe the situation for children has worsened over the past five years; 67% say they would be more likely to vote for a candidate who supported increased spending for children's programs even if it meant a tax increase.

When adults lament the absence of "values," it is worth recalling that children are an honest conscience, the perfect mirror of a society's priorities and principles. A society whose values are entirely material is not likely to breed a generation of poets; anti-intellectualism and indifference to education do not inspire rocket scientists. With each passing day these arguments become more apparent, the needs more pressing. Where is the leader who will seize the opportunity to do what is both smart and worthy, and begin retuning policy to focus on children and intercept trouble before it breeds? ***—Reported by Julie Johnson/Des Moines, Melissa Ludtke/Boston and Michael Riley/Washington***

JAMES KEYSER

GETTING HOOKED: video-game fans in Seaside Heights, N.J.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	re: Managing Trustees Dinner (3 pages)	02/15/1995	Personal Misfile

COLLECTION:
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Melanne Verveer
OA/Box Number: 20041

FOLDER TITLE:
Melissa Ludtke [2]

2013-0534-S
rc1586

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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tremely low birthweight children. Utilities were used to estimate a single value between 0.0 and 1.0 (0 = dead; 1 = perfect health) to reflect the global health-related quality of life for individual children.

Utility scores may be used in assessing the proportion of children whose health-related quality of life is considered worse than death from the perspective of the parents or that of society in general.[16] Saigal is now assessing quality of life in this cohort from the perspective of the children themselves as teenagers.

A comprehensive economic evaluation of neonatal intensive care was done by Boyle and colleagues[17,18] in Canada. This study, reported 12 years ago, needs to be repeated. The feasibility of such a study in the United States is enhanced by ongoing changes in health care reimbursement that provide incentives to health care institutions to determine the true costs of expensive methods of care. My colleagues and I have quantified the resource costs in terms of the number of additional days of intensive care required per survivor (or the number required per survivor without major neonatal morbidity) in different risk groups among infants with birthweights of 501 through 800 g. (Tyson J, Younes N, Verter J, Wright L. Viability, major morbidity, and resource requirements among newborns 501–800 g birth weight. Submitted for publication.)

Although impairment rates of 30% to 40% have been reported in some recent studies of extremely small or preterm infants,[14] only a small proportion of school-age survivors[13,16] have the kind of devastating problems that most parents are likely to consider worse than death. Moreover, the costs of neonatal intensive care—if expressed per life-year gained or per quality-adjusted life-year gained—are likely to be less than those for intensive care of many older children and adults (Tyson et al., submitted manuscript).[17,18] Although these findings seem encouraging, the benefits and hazards as well as the cost-effectiveness of perinatal intensive care relative to other expensive methods of treatment need much more study. Whether or not to administer perinatal intensive care at the margins of viability continues to be an extremely difficult decision that should be based on the best information possible. High priority should be given to developing and implementing improved methods to address the long-term effects of decisions to use perinatal intensive care. □

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Editorial: Can We "Cure" Mild Mental Retardation among Individuals in the Lower Socioeconomic Stratum?

In 1962, the President's Panel on Mental Retardation suggested that the use of existing knowledge could "eliminate perhaps half or more of all new cases of mental retardation."[1(p 47)] The possibility of increasing intelligence quotients gained popularity in the ensuing decade, fueled by a naive belief in the unlimited power of the environment to shape human traits. By 1972 the panel, now called the President's Committee on Mental Retardation, reiterated its suggestion with the strength of a declaration: "Using present knowledge ... it is possible to reduce the occurrence of mental retardation by 50 percent before the end of this century."[2(p31)] President Richard Nixon proclaimed this to be a major national goal, sparking interest in research and intervention activities. As the millennium draws near, it seems appropriate to assess the progress that has been made toward

Editor's Note. See related articles by Kramer et al. (p 312), Murphy et al. (p 319), Yeargin-Allsopp et al. (p 324), and Drews et al. (p 329) in this issue.

halving the occurrence of mental retardation and to speculate whether the goal will be attained—or is in fact attainable.

The presidential advisors did not specify which forms of intellectual retardation might be reduced so dramatically. However, their hopes to lower the prevalence rate rested on both the biological sciences and efforts to improve the environments that seemed to prevent some children from developing their full intellectual potential. This approach presupposes two basic types of retardation, each of which has been further differentiated into a number of subgroups.[3,4] Retardation due to organic causes encompasses genetic disorders, brain damage, and other neurological and metabolic defects that affect the development of formal cognitive structures. Familial retardation (also called cultural familial, retardation owing to psychosocial disadvantage, intergenerational) is a larger diagnostic grouping. Individuals in this category have no identifiable organic disturbance and at least one first-rank relative with the same type of retardation. Organically retarded persons generally (but not always) exhibit severe retardation, whereas those in the familial group are invariably mildly retarded. Organic retardation occurs with equal frequency throughout the socioeconomic strata, but familial retardation is typically found in the lower strata.

The two-group approach to mental retardation is part of a heated controversy over the significance of etiology to behavior and prognosis.[5] On one side of the debate are difference theorists,[6-9] who argue that the only feature relevant to the study of retardation is low IQ, indicative of cognitive development and functioning that are qualitatively different from those of the nonretarded population. On the other side are developmental theorists,[10,11] who believe that how one came to have a low IQ is of primary importance. Those in the organic groups have damaged cognitive apparatus, which affects their intellectual growth and processes. Familial retarded individuals have intact cognitive systems; their low IQs represent the lower portion of the normal distribution of intelligence. In other words, they have the same cognitive structure that develops in the same manner as higher IQ individuals, differing only in the rate at which they traverse the cognitive stages and in the final asymptote they attain.

Resolution of the developmental–difference controversy has profound implications for educational methods and, especially, prevention strategies. If low intelligence reflects abnormal functioning, biomedical research holds the only hope of discovering a cure. But if some nonorganic retardation is to be expected to occur in the population, the hope is not to find a cure but to find ways to enable affected individuals to lead full and productive lives. This long-standing controversy is not about to be resolved in the near future, but my reading of the progress that has been made in reducing mental retardation over the past 3 decades shows that most of the success has been in the organic categories. Familial retardation remains the same mystery today as it has been for most of this century.[10] Medical research continues to hold great promise, but after all the time and effort that have been expended, it seems clear that solutions to alleviate mild retardation will require other approaches.

Intelligence in all individuals is a product of nature and nurture. The nature portion is the most difficult to change, but such change is not impossible. Organic causes of retardation can be alleviated through preventive techniques such as genetic testing and counseling, the elimination of lead and other toxins, and protection from diseases that damage the brain. Familial retardation occurs in impoverished environments that may pose more subtle risks to brain development and functioning. For example, poor nutrition or inadequate shelter may deter the proper growth of the brain. The success of vitamin therapy with some mildly retarded children[12,13] definitely suggests a physical deprivation underlying their poor functioning. In fact, improved health care and nutrition in the general population, purer water and food supplies, and regulation of environmental contaminants are changes that have coincided with an upward trend in standardized intelligence test scores.[14] Healthier environments have been slower to reach the lower socioeconomic strata, where familial retardation most often occurs.

While further improvements in living conditions may eliminate some cases of mild retardation, the phenomenon will never be eradicated if it is part of the normal expression of the population gene pool. The law of human variability dictates that for every continuously distributed human trait, there will always be cases that fall at the lower end of the distribution. However, having limited intellect does not mean that there is no room for improvement. The actual expression, or phenotype, for the genotype for intelligence that one inherits depends on the environment (both physical and social) encountered. The range of environments that the genotype can potentially encounter represents a reaction range. The better the environment, the higher the actual expression of intelligence as reflected in the IQ score. For many mildly retarded persons, encountering a very good environment can place them well within the range of normal functioning. Therefore, optimizing the environments in which children in poverty are raised might reduce the prevalence of mild retardation to some extent.

Efforts to enhance the functioning of impoverished children and those at risk of mental retardation through environmental intervention have met with some success. For example, comprehensive early intervention with low-birthweight infants and their families shows promise for enhancing cognitive development.[15] Although, with very few exceptions,[16,17] attempts to raise intelligence permanently have failed,[9,18] preschool intervention programs have been quite successful in preparing children for school and in boosting their measured intelligence. In fact, the most common outcome of these programs has been an immediate 10-point increase in IQ. These gains have been found to be related to better motivation, familiarity with the test content, and comfort in the test setting[19]—factors that help children make better use of the intelligence they possess. This advantage, however, often fades as they progress through elementary school, perhaps because comparison children catch up during their experiences in school and/or because educational practices fail to build upon the gains made in preschool. An extremely important but often overlooked point is that the loss of higher IQ scores does not necessarily mean that all has been lost. Various studies suggest that longer-lived benefits of preschool involve better achievement, reduced special class placement, improved family functioning, and lessened delinquency and welfare dependency.[20]

Most children who attend preschool intervention programs are not retarded, of course. But they are poor and at risk of failing in school and later in life—the same factors that threaten mildly retarded children. Preschool appears to help poor children behave more competently over time, even though their IQs remain the same. The same result can reasonably be expected for children whose IQs are below the normal range.

Why is it that one person with an IQ of, say, 65 manages to progress through

school, maintain employment, and function as a contributing member of society while another with the same IQ fails in school and requires supervised living and social support? Motivational and emotional variables certainly contribute to these differences in lifestyle. Traits such as poor self-esteem, low expectancy of success, overdependence on external cues, and an "I can't do it" attitude are common in retarded individuals as a result of frequent encounters with failure and personal rejection. Experiences that increase their exposure to success can bolster self-confidence and determination, leading to better performance. In these cases, the "treatment" for mild retardation involves education and training regimens that encourage full use of individual potential by removing psychological barriers.

The question, then, is not how we can "cure" mild mental retardation but how we can encourage those in this category to use fully the intelligence they possess. Comprehensive early childhood intervention for children and families in poverty is one promising strategy. Head Start, for example, has been highly successful in improving the physical well-being and school readiness of poor children by providing health, educational, mental health, and family support services and opportunities for parental involvement. One year of preschool, however, cannot be expected to inoculate children against the ravages of poverty for the rest of their lives. Because children reared in poverty can experience so many developmental threats before they reach age 4, intervention must begin earlier, preferably during the prenatal period. To continue the momentum toward success made during preschool, comprehensive services for children and families should continue during the critical time of transition to elementary school. Other means of prevention and enrichment include universal access to health care, improved nutrition, a cleaner environment, quality schooling, safe neighborhoods, good child care, and services that support families in their roles. Such changes will benefit the entire society, not just those at risk of mild retardation. While these improvements cannot be expected to slice the prevalence of mental retardation in half, they might very well slice the proportion of those who do poorly in school and in life regardless of their intelligence level. □

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Annotation: The Sociodemographic Correlates of Mental Retardation

In a series of three articles in this issue of the Journal,[1–3] investigators at the Centers for Disease Control and Prevention (CDC), the Georgia Division of Public Health, and Emory University provide new data on an old question: namely, the link between mental retardation in children and various sociodemographic characteristics of the children's families. These reports, together with a related article from CDC's National Center for Health Statistics in this same issue,[4] are important in defining the scope of the problem and in identifying children (and their families) who might benefit from early health and educational intervention programs.[5,6]

Recent publications, including *The Bell Curve*,[7] have heightened sensitivity and concern regarding the relationship between sociodemographic factors (especially race) and cognitive ability (or intelligence). Therefore, it is important that we make every effort to put into proper perspective the important articles dealing with this problem that are included in this issue of the Journal. Because there is some disagreement among professionals about the meaning of the terms *mental retardation* and *IQ*, as well as about the measurement of cogni-

Editor's Note. See related articles by Kramer et al. (p 312), Murphy et al. (p 319), Yeargin-Allsopp et al. (p 324), and Drews et al. (p 329) in this issue.

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tive ability in general, the authors of the first three articles are cautious in the interpretation of their findings. For example, Murphy and colleagues state, "We recognize that an IQ test is a measure not of innate intelligence but of performance on a set of skills defined by a specific test instrument and considered relevant to intelligence by the prevailing culture."[1]

Although the method of case ascertainment for mental retardation used in the Georgia study is not synonymous with the prevalence derived from conducting cognitive testing on all children in a given population, the relative prevalence of mental retardation among the various sociodemographic subgroups of children is similar to that found in studies where investigators tested all subjects.[8,9] Thus, these results can be viewed as valid estimates of the relative prevalence of mental retardation within the racial and educational subgroups studied.

The investigators began with a descriptive epidemiologic survey.[1] In this component of their studies, they observed higher prevalence rates of both mild (IQ = 50–70) and severe (IQ < 50) mental retardation among Black 10-year-old children compared with White children of the same age. Because Black and White populations in the United States generally differ with regard to social, economic, cultural, and behavioral factors that affect health, the authors analyzed data from the case–control component of the study to attempt to uncover factors that might explain the Black–White difference.[2] They were able to demonstrate that about one half of the excess of mild mental retardation among Black children was related to a disproportionately high burden of adverse socioeconomic risk factors among the Black mothers, such as low education and residence in neighborhoods with low median family incomes.

The investigators also considered a number of possible explanations for the residual difference in mild mental retardation between Black and White children. These included lack of information on other possible confounding variables; the higher prevalence of certain adverse medical and environmental factors in the Black population (e.g., anemia, lead); intergenerational social, educational, and economic deprivation among Blacks; and differential access to the skills and knowledge assessed in cognitive tests. Although genetic factors have been shown to account for a fair share of the *individual variability* in IQ scores,[10,11] *group differences* raise ecological questions not amenable to the same analysis, and the authors did not speculate on whether genotypic variation may have contributed to those they observed.

In pursuing the search for other sociodemographic risk factors for both mild and severe mental retardation, the authors identified low maternal education (defined as less than 12 years) as the strongest risk factor in their data, independent of the six other factors (including race) that they examined. Mothers with less than 12 years of schooling at the time their children were born were four times more likely to have their children diagnosed as mildly retarded by age 10 years than were mothers with 13 or more years of education.[3] Although the data are not shown in that article, children of both Black and White mothers with less than 12 years of schooling were at almost equally high risk (Pierre Decouflé, ScD, Developmental Disabilities Branch, National Center for Environmental Health, personal communication).

Overall, 54% of children with mild mental retardation in the Georgia study were born to mothers with less than a high school education.[3] Together with the observed elevated risk in this group, the results point to a large portion of mild mental retardation that is potentially preventable. The specific correlates of a low maternal education that directly affect children's cognitive ability could not be identified in this study, but the work of other investigators in the child development field suggests a number of possibilities.[12,13] These include the physical and socioemotional characteristics of the home environment and the quantity and quality of parent–child interactions.

The investigators also clarified the source of the Black–White differential in cases of severe mental retardation. They found that the disparity was confined to the isolated form of the condition in which no other severe neurologic impairment is present.[3] This isolated form of mental retardation is strongly linked with maternal education level. Thus, as is the case with mild mental retardation, the Black–White difference in the severe form may be at least partly an effect of sociodemographic factors other than race.

From a national perspective, three interesting facts emerge about low maternal education. First, of all births in the United States in 1990, about 22% were to women with less than 12 years of education. Second, low maternal education crosses racial and ethnic boundaries. In 1990, White women had 367 196 such births; Hispanic women, 309 054; and Black women, 190 105. Third, low maternal education is not confined to teenage mothers. Of women who gave birth in the United States in 1990 without finishing high school, about 65% were 20 years old or older at delivery.

In another article in this issue of the Journal,[4] data from the third National Health and Nutrition Examination Survey (NHANES III) show that children aged 6 through 16 years from both Black and Mexican-American families and from families with lower incomes or lower education levels had lower mean scores on each of four tests of cognitive functioning. The sociodemographic differences in cognitive ability uncovered in these studies suggest that in certain groups environmental factors raise barriers against optimal intellectual development. Indeed, a recent report from the Carnegie Corporation goes beyond questions of intellectual function and underscores the importance of early (birth to 3 years) experiential and social factors in brain development.[14] The report emphasizes long-lasting effects of early environmental experiences on both brain structure and cognitive function.

I believe that this nation can make a difference in the lives of children by helping to facilitate their early health and learning environments. Thus, in addition to the fine work done by other organizations, CDC is mobilizing resources for a demonstration program aimed at promoting the cognitive, communicative, and behavioral development, as well as the health, of children born to women with fewer than 12 years of education. This effort (Project BEGIN) seeks to determine whether an expanded version of a previously proven early-intervention model[15] can be successfully implemented in diverse community settings and be of decided benefit to participating children and their families.

This early-intervention model is a comprehensive and particularly intensive program, consisting of home visits with the families from birth to age 3 years; enrollment of the child in a full-day, year-round child development center during the second and third years; and parent group meetings throughout the 3-year program. CDC's commitment to the conduct of rigorous, high-quality research together with a neutral stance regarding the effectiveness of early-intervention programs are critical to the success of this new endeavor. Due to the generosity of the Robert Wood Johnson Foundation, CDC has been assisted by a number of

localities in developing the plan for this community intervention project. Because our children are one of the nation's most important resources, we have made this project a priority at CDC. □

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Annotation: Physicians' Attitudes and Decision Making Regarding the Withdrawal of Life Support

During the past few decades, there have been dramatic changes in both the treatment of critically ill patients and in attitudes about how decisions about care should be made. The development of sophisticated technologies has increased the ability to prolong life, which is usually of clear benefit. However, there is growing acceptance of the notion that in some cases treatment may merely prolong the dying process or lead to survival with a very poor quality of life. Indeed, it is now nearly 20 years since Karen Ann Quinlan ceased breathing on the night of April 15, 1975,[1] and the ensuing court case thrust decision making about withdrawal of life support into the public arena.

Formerly, choices about life-sustaining treatment were seen primarily as medical decisions for physicians to make. The debates about criteria for withdrawing life support led to clearer recognition that such decisions cannot be based only on objective facts but must always reflect value judgments about issues such as the meaning of life and death, the quality of life, and the proper use of technology. Therefore, in parallel over the past 20 years, the principle of patient autonomy has steadily gained ground. Court decisions, statutes, and professional standards have supported the right of competent patients to make decisions to forgo treatments, either directly or through the use of advance directives (living wills and health care proxies).[2]

Despite the clear guidelines, empirical research has shown that many factors prevent adherence to patients' preferences about care at the end of life.[3] This situation affects public health not only because care thought to be inappropriate can cause suffering for patients and families but also because the inappropriate prolongation of treatment uses health care resources for unwanted care. Little is known, however, about the extent to which actual treatment decisions vary from patient preferences. For many reasons, this topic is very difficult to study. One problem is that research would need to uncover patient preferences that may never have been explored; another problem is that these decisions are made when patients and their families are in crisis. One way to address the issue is to look at physician responses to hypothetical situations and ask them about how they would treat terminally ill patients. The research conducted by Christakis and Asch,[4] reported in this issue of the Journal, is important because it demonstrates that physicians' characteristics affect both attitudes and practices related to the withdrawal of life support. Although the response rate to their survey was lower than that usually reported in this Journal, the article is an important contribution because it is one of the first to provide data on the relationship of attitudes to practice.

Christakis and Asch presented hypothetical vignettes and asked physicians to indicate treatment choices in order to study responses to the most clear-cut type of case: a terminally ill, comatose patient who had previously stated, and whose family currently indicated, that under the circumstances presented they would want life supports withdrawn. Nevertheless, responses varied; many physicians chose to give life-sustaining treatments. In addition, unlike many previous studies that examined only attitudes, this study asked physicians to report on their actual practices. Professional characteristics such as specialty and work setting, personal characteristics such as age and religion, and the attitudes manifested in the responses to the vignettes were associated with the number of times the respondents said they had withdrawn life support during the last year.

Editor's Note. See related article by Christakis and Asch (p 367) in this issue.

Health and Social Characteristics and Children's Cognitive Functioning: Results from a National Cohort

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ABSTRACT

Objectives. The purpose of this study was to examine the associations between cognitive functioning in children and sociodemographic, family, and health characteristics.

Methods. Data from phase 1 of the third National Health and Nutrition Examination Survey were used to evaluate performance on standardized cognitive tests in a representative sample of 2531 children 6 to 16 years of age. Multivariate analyses were used to assess independent associations between covariates and test performance.

Results. Lower income, minority status, and lower education of an adult reference person (one of the persons in the household who owned or rented the home) were independently associated with poorer performance on all cognitive subtests. To a lesser degree, general health status, history of birth complications, and sex also were independent predictors of performance for some of the subtests.

Conclusions. These findings illustrate disparities in cognitive functioning across sociodemographic and health characteristics of children in the US population. They suggest the need for public health policies to take a multifaceted approach to optimizing childhood environments in order to overcome the effects of socioeconomic and minority status. (*Am J Public Health.* 1995;85:312–318)

Introduction

Improving the health and well-being of each child is paramount among the national goals for the field of public health.[1] Over the past 4 decades, the health profile of children has changed its focus from largely infectious diseases to troubles affecting overall health, including emotional, psychological, and learning problems. The intellectual development and academic performance of children have become public health concerns because of their implications for the future performance and quality of life of individuals and society as a whole.

Intellectual development results from a complex interaction of environmental, social, and hereditary factors.[2–6] Investigation of the relative contribution of these elements has revealed variability in functioning with regard to a number of sociodemographic and environmental characteristics. Lower intellectual functioning and academic achievement have proved to be associated with minority status and socioeconomic position (e.g., income, education, and household composition).[3,7–16] Disparities have also been observed across geographic regions and various health and nutritional indicators.[3,17–22] Other developmental risk factors associated with the "host" environment, such as complications during birth, age of mother at the time of birth (both older and younger mothers present potential risk), and maternal smoking during pregnancy have also been linked to subsequent deficiencies.[5,23–30]

Disentangling the relative impact of these individual characteristics is complex because of the high correlations among them. In particular, children in lower income households tend to be disproportionally Black, live in a single-parent household, and have parents with lower educational levels.[31] Poverty is also associated with compromised general health as a result of less than adequate access to health care, poor environments, and inadequate nutrition.[31,32]

The third National Health and Nutrition Examination Survey (NHANES III) offered an opportunity to evaluate the collective and independent contributions of sociodemographic factors, family characteristics, and health indicators to intellectual development and academic performance within a national sample. The objective of this paper is to present an overall picture of the association of children's cognitive functioning with these factors and thereby help guide public health policy focused on creating optimal environments for children.

Methods

NHANES III was a 6-year (1988 to 1994) survey conducted by the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention. A stratified multistage clustered probability design involving two 3-year phases was used to select a sample of the civilian noninstitutionalized US population 2 months of age and older.[33] Each

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Editor's Note. See related editorial by Zigler (p 302) and annotation by Satcher (p 304) in this issue.

phase produced a representative national sample, the first of which was used for this analysis. Data were collected through a household interview and a physical examination conducted in a specially equipped mobile examination center.[34]

Dependent Variables

The dependent variables were scaled scores from two subtests (Block Design and Digit Span) of the Wechsler Intelligence Scale for Children–Revised (WISC-R) and two subtests (Reading and Arithmetic) of the Wide Range Achievement Test–Revised (WRAT-R).[35,36] These inventories are widely used psychometric tools designed to assess general intelligence and simple academic coding skills, respectively.[2,35,36] In its entirety, the Wechsler Intelligence Scale for Children–Revised can be used to estimate an individual's IQ; NHANES III included only two subtests of the scale to serve as indicators of cognitive functioning rather than to provide an actual IQ score. The subtests were selected, in part, because they are among the least likely of Wechsler's Verbal and Performance subtests to be culturally loaded.[37] The scaled scores for all four subtests were on a common scale and derived for each child relative to his or her age group, based on test-specific standardization samples created by the test developers.[35,36]

The tests were administered in a standardized environment during the physical examination to all children 6 to 16 years of age by trained interviewers according to standardized procedures.[35,36] Ninety-five percent of the children were tested in English, and the remainder were tested in Spanish. Adherence to the protocol, accurate timing of the tasks, and data collection were enhanced by an automated data recording system. Quality control activities were conducted throughout the survey and indicated consistent adherence to the protocol.

Independent Variables

Data collected during the household interview, as reported by the examined child or a knowledgeable informant, were used for the independent variables.

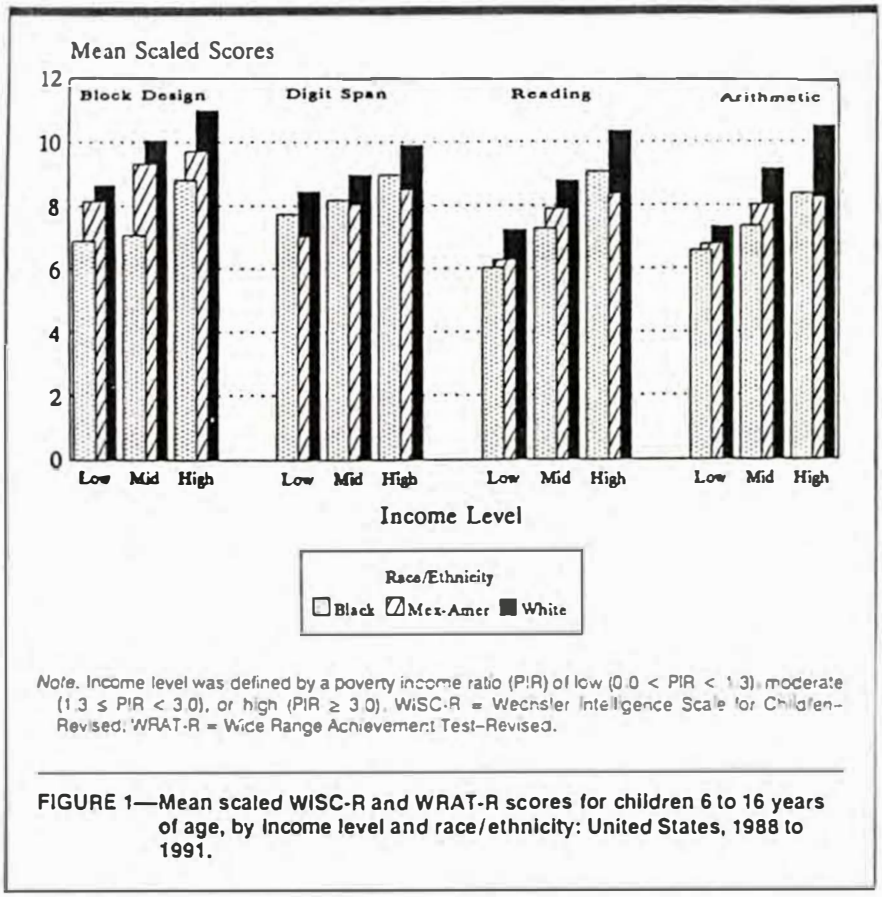
Demographic characteristics. Age at examination was defined in years and months. A composite race/ethnicity variable divided the sample into four groups: non-Hispanic White, non-Hispanic Black, Mexican American, and other. The terms Black and White are used here to refer to the non-Hispanic Black and non-Hispanic White populations.

TABLE 1—Weighted Mean Scaled WISC-R and WRAT-R Subtest Scores in Children 6 to 16 Years of Age, by Covariates: United States, 1988 to 1991

Covariate	No.[a]	WISC-R Subtest Score, Mean (SD)		WRAT-R Subtest Score, Mean (SD)	
		Block Design	Digit Span	Reading	Arithmetic
Sex					
Male	1242	9.70 (0.19)	8.66 (0.16)	8.12 (0.19)	8.47 (0.15)
Female	1289	9.28 (0.18)	8.98 (0.16)	8.73 (0.17)	8.93 (0.12)
Race/ethnicity					
Non-Hispanic Black	711	7.18 (0.19)	8.01 (0.14)	6.77 (0.21)	7.05 (0.15)
Mexican American	1044	8.59 (0.11)	7.42 (0.20)	6.86 (0.40)	7.23 (0.12)
Non-Hispanic White	776	10.11 (0.22)	9.14 (0.19)	8.95 (0.19)	9.22 (0 17)
Income level[b]					
Low	1084	8.04 (0.21)	8.02 (0.19)	6.71 (0.18)	7.02 (0.20)
Moderate	831	9.62 (0.20)	8.80 (0.22)	8.54 (0.16)	8.85 (0.21)
High	381	10.84 (0.14)	9.81 (0.19)	10.20 (0.25)	10.30 (0.21)
Education[c]					
Less than high school	1093	8.02 (0.20)	7.78 (0.17)	6.67 (0.16)	6.92 (0.23)
High school	781	9.28 (0.21)	8.58 (0.22)	8.13 (0.16)	8.37 (0.17)
More than high school	636	10.65 (0.14)	9.71 (0.17)	9.85 (0.25)	10.16 (0.16)
Size of household					
1–4 persons	1091	9.76 (0.19)	9.02 (0.12)	8.91 (0.13)	8.95 (0.13)
5+ persons	1440	9.16 (0.21)	8.55 (0.19)	7.79 (0.21)	8.37 (0.16)
Region					
Midwest	483	9.92 (0.32)	9.20 (0.22)	8.73 (0.30)	9.14 (0.13)
South	882	9.04 (0.33)	8.62 (0.16)	8.29 (0.20)	8.29 (0.24)
West	929	9.74 (0.22)	8.53 (0.19)	7.85 (0.32)	8.73 (0.27)
Northeast	237	9.56 (0.22)	8.92 (0.57)	8.79 (0.37)	8.82 (0.17)
General health status					
Fair/poor	224	7.96 (0.49)	6.96 (0.31)	6.27 (0.46)	7.15 (0.44)
Very good/good	1425	9.01 (0.25)	8.42 (0.12)	7.86 (0.17)	8.09 (0.18)
Excellent	882	10.12 (0.14)	9.37 (0.18)	9.17 (0.19)	9.44 (0.14)
Marital status[d]					
Married	1766	9.76 (0.18)	8.94 (0.15)	8.72 (0.15)	9.04 (0.15)
Not married	755	8.63 (0.24)	8.40 (0.20)	7.43 (0.25)	7.55 (0.25)
Mother's age at birth,[e] y					
Less than 18	151	8.10 (0.59)	8.21 (0.28)	6.61 (0.62)	8.02 (0.32)
18–35	1451	9.57 (0.20)	8.89 (0.15)	8.02 (0.18)	8.79 (0.18)
Greater than 35	68	10.58 (0.64)	9.31 (0.71)	9.06 (0.69)	8.72 (0.56)
Birth complications[e]					
Yes	184	9.52 (0.40)	8.45 (0.35)	7.31 (0.40)	8.31 (0.47)
No	1386	9.51 (0.18)	8.95 (0.15)	8.11 (0.13)	8.82 (0.15)
Prenatal smoke exposure[e]					
Yes	344	9.05 (0.26)	8.63 (0.18)	7.40 (0.32)	8.19 (0.28)
No	1324	9.68 (0.20)	8.97 (0.16)	8.24 (0.15)	8.95 (0.17)

Note. WISC-R = Wechsler Intelligence Scale for Children–Revised; WRAT-R = Wide Range Achievement Test–Revised.
[a]Unweighted sample size.
[b]Defined by poverty income ratio (PIR) of low (0.00 < PIR < 1.30), moderate (1.30 ≤ PIR < 3.00), or high (PIR ≥ 3.00).
[c]Years of education completed by the adult reference person.
[d]Marital status of the adult reference person (yes indicates married or living as married, no indicates all other responses).
[e]Collected only for 6–11-year-olds.

Annual family income was used to calculate a poverty income ratio, defined as the ratio of the total family income to a poverty threshold for the year of interview, adjusted for family size.[38–40] A poverty income ratio of 1.00 or higher represents those at or above the US poverty level. In analyses, this ratio was used as both a continuous and a categorical variable (a low poverty income ratio was defined as one of less than 1.30; a moderate ratio, as one between 1.30 and 2.99; and a high ratio, as one of 3.00 or greater). The categorization was selected



Note. Income level was defined by a poverty income ratio (PIR) of low (0.0 < PIR < 1.3), moderate (1.3 ≤ PIR < 3.0), or high (PIR ≥ 3.0). WISC-R = Wechsler Intelligence Scale for Children-Revised; WRAT-R = Wide Range Achievement Test-Revised.

FIGURE 1—Mean scaled WISC-R and WRAT-R scores for children 6 to 16 years of age, by income level and race/ethnicity: United States, 1988 to 1991.

to be consistent with criteria used by the US Department of Agriculture for food stamp eligibility.[41]

Information was also collected on an adult reference person, defined as one of the persons in the household who owned or rented the home (most often the parent). The highest grade of education attained for the adult reference person was categorized into three groups (<12 years, 12 years, and >12 years). The marital status of the reference person was dichotomized into married or living as married vs all others.

Number of persons per household was dichotomized into an indicator of household size (1 through 4 and 5+) that divided the sample close to the median for size and was consistent with the variable used to create the sample weights. The regional divisions were defined by the US census: Midwest, South, West, and Northeast.

Health status and host characteristics. General health status was based on responses to the following question: "Would you say the child's health in general is excellent, very good, good, fair, or poor?" Three categories were derived: excellent health, very good or good health, and fair or poor health.

Information on host characteristics (age of mother at birth, birth complications, and prenatal smoking) were collected only for children 6 to 11 years of age. The age in years of the biological mother at the time of birth was divided into three categories (<18, 18 through 35, and >35). A history of birth complications was based on a report of birthweight less than 2500 g and/or the response to the following question: "Did the child receive any newborn care in an intensive care unit, premature nursery, or any other type of special care facility?" A history of prenatal smoking exposure was based on the response to the question "Did the child's mother smoke at any time while she was pregnant with the child?"

Analytic Sample and Response Rates

Of the 3261 children 6 to 16 years of age who were selected to participate in the survey, 2965 were interviewed and eligible for examination. Of those children, 2778 were examined, and 2624 had a score for at least one of the cognitive subtests (an overall response rate of 80% [2624/3261]).

The final analytic sample was limited to those children who were non-Hispanic White, non-Hispanic Black, and Mexican American (n = 2531). Children identified as belonging to other races/ethnicities were excluded from the sample because of the small size (n = 93) and heterogeneous nature of the subgroup.

The potential effect of nonresponse on the estimates for cognitive functioning was evaluated by comparing observed and expected scores according to previously used methods.[42-44] Missing values for the test scores were more common among the youngest children, yet no apparent bias due to differential nonresponse was detected.

Statistical Analysis

All analyses, unless specifically noted, incorporated the sampling weights and survey design of NHANES III.[33,45] SUDAAN,[46] a statistical software package compatible with SAS,[47] was used to determine standard errors for the estimates, taking into account both the weights and the complex survey design.

Weighted mean scaled scores and accompanying standard errors were calculated for the four subtests, with stratification by the covariates. For each subtest, multiple linear regression models were then separately constructed for two age groups (6 to 11 years [n = 1686] and 12 to 16 years [n = 849]), with the scaled score serving as the dependent variable. Initially, models were run with the full set of covariates; they were then reduced by removing variables that failed to reach significance ($P < .05$) in all models so as to arrive at a common set of covariates. The reduced models included sex, race/ethnicity, income, education of the adult reference person, general health status, and a history of birth complications (6- to 11-year-olds only). The direction and magnitude of the associations of these covariates with the test scores were comparable in both the full and reduced models. Interaction terms were also introduced but not included in the reduced models because they added little to the fit or failed to reach statistical significance. A small proportion of children were missing information on income level (9%), education of the reference person (1%), and history of birth complications (7%) and thus could not be included in the final models.

Additional analyses were conducted to evaluate the sensitivity of the findings and potential sources of bias. Models were run with modified samples of (1) only those administered the test in English (n = 2401) to examine the influence of Spanish administration and (2) only

one child per family (n = 1125 for the 6- to 11-year group and n = 596 for the 12- to 16-year group) to remove the potential effect of the shared environment and genetic background of clusters of siblings. A single child was chosen from families with more than one child (707 families) through a random selection process within each age category. Models run on both modified data sets demonstrated results comparable in direction and significance to those from the full sample.

Results

Univariate Analyses

The unweighted sample sizes, weighted mean scaled scores, and accompanying standard errors for the four subtests, stratified by the covariates, are presented in Table 1. As expected, lower scores tended to be associated with a lower socioeconomic status. Children with lower family income and level of education of the reference person, an unmarried reference person, and a larger household had uniformly lower test scores.

Lower scores were also associated with minority status. Mean scores were generally highest among White children, intermediate among Mexican Americans, and lowest in Black children.

Test scores also varied according to health-related factors. Children with poorer general health and prenatal exposure to smoke scored lower on all four subtests. Those with a history of birth complications scored lower on all but Block Design. In addition, children born to young mothers demonstrated consistently lower test scores.

The differences in test scores according to sex and region were small and less consistent. Girls performed better than boys, on average, on the Digit Span, Reading, and Arithmetic subtests, while boys performed better on Block Design. Children from the Midwest performed better, on average, than those in the other regions on all of the subtests except Reading, on which children in the Northeast had the highest mean score.

Stratified Analyses

After the data had been further stratified, disparities among race/ethnicity groups were observed in all income levels; mean scores were higher among White children than among minority (Black and Mexican American) children, regardless of income level (Figure 1). Mean test scores were also consistently higher among children in higher poverty income ratio categories, regardless of race/ethnicity. In a similar fashion, the race/ethnicity differences persisted when they were examined in the context of education of the reference person, general health status, and presence of birth complications (data not shown).

TABLE 2—Coefficients from Linear Regression Analysis of Age-Standardized WISC-R Scores, by Age Group: United States, 1988 to 1991

Covariate	Block Design, Coefficient ± SE		Digit Span, Coefficient ± SE	
	6–11-Year Group	12–16-Year Group	6–11-Year Group	12–16-Year Group
Sex				
Male	0.43 ± 0.19*	0.29 ± 0.35	−0.45 ± 0.21*	−0.16 ± 0.30
Female	0.00	0.00	0.00	0.00
Race/ethnicity				
Non-Hispanic Black	−1.64 ± 0.29**	−3.05 ± 0.38**	−0.15 ± 0.26	−1.24 ± 0.34**
Mexican American	−0.20 ± 0.29	−0.31 ± 0.35	−0.57 ± 0.26*	−0.88 ± 0.31**
Non-Hispanic White	0.00	0.00	0.00	0.00
Income level[a]	0.56 ± 0.16**	0.31 ± 0.10**	0.25 ± 0.11*	0.37 ± 0.12**
Education[b]				
Less than high school	−1.37 ± 0.42**	−1.96 ± 0.37**	−1.11 ± 0.32**	−1.03 ± 0.33**
High school	−0.97 ± 0.40*	−0.52 ± 0.28	−0.64 ± 0.24*	−0.89 ± 0.36*
More than high school	0.00	0.00	0.00	0.00
General health status				
Fair/poor	−0.96 ± 0.66	−0.58 ± 0.69	−1.60 ± 0.50**	−1.19 ± 0.29**
Very good/good	−0.15 ± 0.28	−0.62 ± 0.33	−0.34 ± 0.18	−0.65 ± 0.27*
Excellent	0.00	0.00	0.00	0.00
Birth complications[c]				
Yes	−0.15 ± 0.25		−0.53 ± 0.35	
No	0.00		0.00	
R^2	0.17	0.27	0.09	0.18

Note. WISC-R = Wechsler Intelligence Scale for Children–Revised. The last category serves as the reference category for categorical variables.
[a]Defined as a continuous value for the poverty income ratio.
[b]Years of education completed by the adult reference person.
[c]Collected only for 6–11-year-olds.
*$P < .05$; **$P < .01$.

Multivariate Analyses

After all of the covariates had been controlled, income level, race/ethnicity, and educational level demonstrated significant independent associations with each of the subtests. Greater family income was significantly associated with higher test scores in all models. Similarly, White children performed significantly better than Black children on all tests, with the exception of Digit Span and Reading in younger children. The difference between Whites and Mexican Americans was significant only on Digit Span (for both age groups) and Arithmetic (for older children). Greater education of the reference person was associated with higher test scores in all models.

The remaining covariates, including sex, general health status, and presence of birth complications, were less consistently associated with the test scores. Sex was significantly associated with performance only among 6- to 11-year-olds; boys scored higher on Block Design, and girls scored higher on the other three subtests. General health status and the presence of birth complications were generally consistent in the direction of their association with the test scores, but they were not consistently significant. Children 6 to 11 years old with poorer health scored significantly lower only on Digit Span and

TABLE 3—Coefficients from Linear Regression Analysis of Age-Standardized WRAT-R Scores, by Age Group: United States, 1988 to 1991

Covariate	Reading, Coefficient ± SE		Arithmetic, Coefficient ± SE	
	6–11-Year Group	12–16-Year Group	6–11-Year Group	12–16-Year Group
Sex				
Male	−1.00 ± 0.24**	−0.16 ± 0.23	−0.64 ± 0.21**	−0.32 ± 0.23
Female	0.00	0.00	0.00	0.00
Race/ethnicity				
Non-Hispanic Black	−0.57 ± 0.29	−2.18 ± 0.42**	−0.68 ± 0.24*	−2.14 ± 0.21**
Mexican American	−0.34 ± 0.47	−0.53 ± 0.46	−0.21 ± 0.27	−0.93 ± 0.27**
Non-Hispanic White	0.00	0.00	0.00	0.00
Income level[a]	0.56 ± 0.14**	0.66 ± 0.18**	0.59 ± 0.14**	0.55 ± 0.14**
Education[b]				
Less than high school	−1.55 ± 0.34**	−2.41 ± 0.35**	−1.57 ± 0.29**	−2.66 ± 0.45**
High school	−0.88 ± 0.27**	−1.17 ± 0.39**	−1.10 ± 0.37**	−1.12 ± 0.48*
More than high school	0.00	0.00	0.00	0.00
General health status				
Fair/poor	−1.65 ± 0.60*	−0.64 ± 0.61	−0.42 ± 0.75	−0.80 ± 0.56
Very good/good	−0.17 ± 0.25	−0.97 ± 0.27**	−0.32 ± 0.22	−0.99 ± 0.29**
Excellent	0.00	0.00	0.00	0.00
Birth complications[c]				
Yes	−0.85 ± 0.34*		−0.79 ± 0.39	
No	0.00		0.00	
R^2	0.15	0.34	0.17	0.32

Note. WRAT-R = Wide Range Achievement Test–Revised. The last category serves as the reference category for categorical variables.
[a]Defined as a continuous value for the poverty income ratio.
[b]Years of education completed by the adult reference person.
[c]Collected only for 6–11-year-olds.
*$P < .05$; **$P < .01$.

Reading; older children with poorer health scored lower on Digit Span, Reading, and Arithmetic. Among the 6- to 11-year-olds, those with birth complications scored significantly lower only on the Reading subtest.

The percentage variations in the test scores explained by the set of variables included in these models are represented by the R^2 values provided in Tables 2 and 3. These variations ranged from 9% on the Digit Span subtest to 34% on the Reading subtest.

Discussion

The data from phase 1 of NHANES III demonstrate that poorer performance on standardized measurements of cognitive functioning was independently associated with minority status, lower income, and less education of an adult reference person in a national sample of children. Although less consistent as independent predictors of test performance, general health status, history of birth complications, and sex also demonstrated independent effects on the measurements of intellectual functioning and academic achievement.

These findings help refine an understanding of the factors associated with cognitive functioning for the US population of children. They emphasize the importance of using a multifaceted approach when advocating for environments that allow children to reach their full potential. Although physical health status and host characteristics are important areas for intervention, the effects of poverty, lack of adequate education, and being a member of a minority are most consistent in their independent associations with poorer performance. As a result, effective public health initiatives designed to enhance a child's chances for developing skills and knowledge must include multiple levels of intervention.

The NHANES III results are unique in that they are a product of the latest national survey providing estimates using highly standardized methods and a large representative, unbiased sample of US children. NHANES III was the first survey to include a large national sample of Mexican Americans, the fastest growing minority group in the United States. It was also designed to include large samples of Blacks and children so that estimates could be produced with acceptable precision. Because of its magnitude, it provides sufficient power to simultaneously examine the associations between cognitive test scores and sociodemographic, general health, and family characteristics.

Despite the strengths of the data collected in NHANES III, there are also some limitations. As with most survey data, potential biases associated with nonresponse, either through refusal to participate in the survey or due to item nonresponse, may exist. Although the overall response rate was relatively high (80%) and evaluation of the effect of nonresponse on test scores failed to detect an apparent bias associated with nonparticipation, there is still room for additional biases not measured in these analyses. Item nonresponse for the income variable, in particular, presents a potential source of bias since 9% of the sample could not be included in the multivariate analyses as a result of missing data.

In addition, a potential bias may have resulted from the influence of bilingualism and acculturation on performance among Mexican American children.[48,49] Other dimensions of the testing context may have also produced bias in performance among selected subgroups. The volley of requests from medically garbed (predominantly non-Black) examiners in the mobile examination center was potentially distracting and perhaps anxiety provoking for young children and Blacks. Black children, in particular, may have been accustomed to different cultural norms for interacting with adults and may have found it difficult to adjust to an unfamiliar environment.[50]

Finally, the small proportion of variability (9% to 34%) explained by the

models represents a limitation to the findings and may have been due to factors not available from the NHANES III data set. Considering the complexity of intellectual functioning and the range of variability explained by other investigators (20% to 60%), it is not surprising that we were unable to account for a larger percentage.[7,10,17,51,52]

Keeping these limitations in mind, the findings from this study can be distinguished for their general agreement with the existing literature on cognitive functioning in children. Similar predictors of performance on cognitive tests have been demonstrated in reviews of the literature and prior prevalence studies.* In particular, an earlier version of NHANES III (cycles 2 and 3 of the Health Examination Survey, 1963 to 1970) also presented associations among subtests of the Wechsler Intelligence Test for Children–Revised and Wide Range Achievement Test–Revised and race, sex, family income, parental education, and geographic region.[17–19,56]

Whereas other investigators have presented evidence supportive of associations between cognitive abilities of children and marital status of parents, household size, age of biological mother at birth, and a history of prenatal smoking, our results did not replicate these findings.[7,27,28] Inconsistencies between our findings and those of other investigators may be due to the inability of other studies to adequately control for confounding factors such as income, parental education, or race/ethnicity.

The demonstrated patterns of race/ethnicity differences have been proposed by some to result primarily from inherent cultural biases associated with standardized tests. Some researchers have even proposed a race/ethnicity-specific differential in the predictive ability of IQ tests for achievement, such that tests of intelligence predict achievement most successfully in White children.[57] The literature does not consistently support such contentions,[2,49,58,59] however, and often maintains that tests of intelligence and ability are equally good predictors for Black, White, and Mexican American children.[2,60] Nonetheless, it is important to keep in mind that subtle effects of culture may still influence performance and should be taken into account when interpreting test results.

Whether the variability observed in this analysis is real or the result of limitations in the cognitive tests cannot be adequately discerned from the available data. Assuming that the differences are real, the implication is that remedies focused on income alone cannot overcome the inequities introduced by a history of limited opportunities for Blacks and Hispanics. Critical contrasts in experience and life-style specific to race/ethnicity groups remain even after the effects of social class and economic status have been removed.[2]

Possible mechanisms of action for both race/ethnicity and income may work through similar channels by reducing access to resources that increase the chances for development of skills and knowledge. Children of minority status and those living in poverty face difficult challenges related to physical and emotional health, housing, educational and social opportunities, nutrition, and general discrimination and racism in US society.[2,48,59,61,62] These factors, in conjunction with characteristics specific to minority cultures (e.g., culture-specific attitudes, values, and motivations and native language), have been postulated to contribute to a child's performance on standardized cognitive tests.[2,49,58,59,61,62]

Independent of race/ethnicity and income, the educational level of the adult reference person also proved to be an important predictor of performance. The education of the reference person, who may be a parent or adult living in the household, could represent both environmental and hereditary contributions to a child. Some studies have found that intellectual functioning and academic achievement of parents are by far the strongest predictors of a child's intellectual functioning.[3,63] The educational level of adults living in a child's household, regardless of whether they are parents, may also be viewed as an indicator of the household's "human capital."[64] This capital provides a resource for a child and would naturally be augmented with greater education of the reference person. The investment of a household's human capital in the development of a child would surely contribute to that child's cognitive functioning.

The differential effects of the remaining variables included in the models suggest independent associations between test performance and sex, health status, and a history of birth complications. The general implications of these findings are that being male, having compromised health, and having a history of birth complications are all associated with poorer cognitive performance on selected subtests.

To meet the goals of providing optimal environments for children, it is clearly important to diminish the adverse effects of race/ethnicity, poverty, and compromised physical health on cognitive functioning. Current population estimates suggest that the US population has exhibited an increase in the percentage of minority children and an increase in the number of impoverished children across all race/ethnicity groups.[65] Such changes in the configuration of the population make the apparent associations among poverty, minority status, and the cognitive functioning of children even more important as a focus for the implementation of programs to improve the health of US children.

Further investigation is warranted to account for the unexplained variability in test performance and to identify modifiable factors that may improve functioning. Research focused on causal mechanisms for cognitive functioning will also aid in the development of appropriate remedies. These results indicate that, as America becomes more diverse, greater efforts need to be directed toward improving access to economic and educational opportunities and removing obstacles such as poor health and the possible effects of discrimination and racism. Such efforts are essential if we are to prepare for a healthy and productive population in the next century. □

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Commentary

Politics and Practice: Introducing Norplant into a School-Based Health Center in Baltimore

ABSTRACT

As one element of Baltimore's effort to combat its high rate of teenage pregnancy, the Baltimore City Health Department added the implantable contraceptive Norplant to the array of services offered at one of its school-based health centers in early 1993. The initial findings with the adolescents who received this contraceptive at the school were favorable, particularly regarding condom use, parental involvement, and patient acceptance of the contraceptive. This new policy garnered a significant amount of attention, both nationally and locally. It attempts to address problems that have complicated etiologies as well as diverse clinical, social, and ethical ramifications, all complicated by political realities. The Norplant experience offers useful lessons regarding controversial health initiatives that address problems facing public health practitioners today. (*Am J Public Health.* 1995;85:309–311)

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Introduction

The city of Baltimore has long had one of the nation's highest adolescent birth rates. The emotional, social, and economic costs of this problem are significant. In 1990, 10% of all 15- to 17-year-olds living in Baltimore gave birth, with direct costs of teenage births to the government (through Aid to Families with Dependent Children [AFDC]; the special supplemental food program for Women, Infants, and Children [WIC]; food stamps; and Medicaid) of $222 million.[1] Health risks to adolescent mothers and their children are well documented, ranging from pregnancy complications such as preeclampsia to low-birthweight babies.[2] In addition, there are the long-term consequences of lower levels of educational and job attainment for the mothers and higher rates of living in poverty for their offspring.[3,4]

Over the past decade, many different approaches have been attempted to combat the problem of adolescent pregnancy and birth in Baltimore. These approaches include (1) the development of an inner-city, mall-based comprehensive health clinic that provides a host of services, including family planning, to over 5000 adolescents each year; (2) a citywide media campaign promoting abstinence; (3) school-based efforts, including peer-taught and teacher-taught abstinence curricula in middle schools, male outreach activities, and sex education; and (4) the development of family planning services in two middle and six high school–based comprehensive primary care centers. These activities have resulted in some success. After several years of increasing rates, Baltimore's adolescent birth rate has stabilized (Baltimore City Health Department, unpublished natality statistics, 1992). However, it remains among the highest in the country, and further approaches are being considered.

One widely discussed approach is making the implantable contraceptive Norplant more readily accessible to adolescents. Norplant has been available to adolescents in Baltimore City Health Department family planning clinics since the summer of 1992. However, clinicians working in the health department's school-based health centers, after hearing requests for Norplant from students and parents, felt that these centers would be the best setting for adolescent Norplant insertions and would provide the best access to this contraceptive.

The Baltimore City Health Department operates school-based health centers that provide comprehensive primary and preventive health care to enrolled students at eight secondary schools.[5] These schools are all in locations where there is a particular need for accessible adolescent health care.

Family planning counseling and exams have been available on site at the school-based health centers since their inception in 1985. Vouchers for contraceptives, to be redeemed at off-site locations, were given to students who desired them. However, this voucher system did not work well because students rarely followed up to obtain contraceptives. To alleviate this problem, the health department decided to make oral contraceptives, foam, and condoms available in the health centers at the start of the 1990/91

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school year. The decision became policy only after an extensive survey of parents of students enrolled in the clinics demonstrated strong support (75% in favor) for offering contraceptives on site.[6] The contraceptive availability policy has been very well accepted by students, staff, and parents. A follow-up survey in the second year of this policy revealed no parental complaints about the availability of contraceptives on site (P. Beilenson, unpublished data, 1991).

The Decision and the Reaction

As Norplant began to be discussed in the general media, health care professionals in the school-based health centers were asked by students and parents about its availability in these sites. These requests, combined with the fact that the current contraceptive policy was so well accepted by parents, led the commissioner of health to decide to make Norplant available on a pilot basis at one of the health department's school-based health centers in the 1992/93 school year.

The school chosen as the pilot site, a combined middle and high school for pregnant and parenting teens, was selected for two reasons. First, adolescents who have already given birth are at even higher risk of pregnancy than other adolescents.[7] Second, the principal of this school was very supportive of the program.

In December 1992, as the health department's Bureau of School Health began to develop the structure for this pilot program, the media learned that Baltimore would be the first city in the nation offering Norplant at a school-based health center. The media coverage—local, national, and international—was almost universally favorable and plans for implementing the pilot program were finalized.

However, in late January 1993, shortly after the first Norplant was inserted at the school, a small but vocal group of citizens spoke out in opposition to the program. This group contended that the Norplant policy targeted inner-city African-American teenagers (some argued that this amounted to "genocide"); that Norplant had not been tested in this population; that Norplant users would be less likely to practice safer sex and therefore would be at higher risk for human immunodeficiency virus (HIV) and other sexually transmitted infections; that the health department was promoting the use of this contraceptive over abstinence; that Norplant had dangerous side effects; and that the program excluded families from the decision-making process of their adolescents.[8,9]

The strategies used by the opposition were similar to those used nationally against other school health programs instituting reproductive care. These strategies included misinformation, manipulation of public meetings, preying on fears of parents, intimidation and pressure tactics, and accusations of racism.[10]

To ensure that these concerns got a public airing, a city councilman introduced legislation calling for a hearing on the health department's policy of offering Norplant in the schools. The hearing, held in early February 1993, was contentious. The opponents' claims were refuted (Appendix) and their public opposition to the program subsided as it became obvious that the general public was in favor of making Norplant available as long as it was not promoted and no coercion was involved. The Norplant program continued during the hearing process and Norplant continues to be available to students in the school-based health center.

Outcomes

In the first semester after the new policy was implemented, 11 of the approximately 100 nonpregnant students in the school received Norplant from the school-based health center. Before receiving Norplant, each of these 11 students attended a counseling session at the school, accompanied by a parent or guardian; in most instances, a relative was also present during the insertion procedure. All of the students have tolerated Norplant well; there have been no requests for removal and no students have exhibited any but minor side effects. All of these students reported using condoms at least as frequently as they did before receiving Norplant (with follow-up of 5 to 12 months), and most reported using condoms significantly more frequently since getting the implant. As support for these students' self-reports on condom use, we know of only a single case of a sexually transmitted disease among these Norplant recipients. One possible explanation for this increased use of condoms is the intensive counseling on condom use all students receive before getting the implant, combined with extensive follow-up counseling.

Plans for the Future

With the successful implementation of this policy, the health department has expanded the availability of Norplant to three more high schools, with plans to expand to the remaining two high schools that have school-based health centers over the next year. (The implant will not be available in the two middle school health centers.) In light of the controversy the initial proposal generated, however, the health department educated various segments of the community about Norplant before this expansion. The health department (1) discussed the issue with religious groups and a city-wide community health advisory group; (2) discussed the issue with interested parents in each school; (3) educated the teaching and administrative staffs of the schools; and (4) made presentations to student groups about postponing parenting, including a discussion of abstinence, Norplant, and other contraceptive methods.

Discussion

If community acceptance can be obtained, school-based health centers are ideal places to offer contraceptive services. They are readily accessible to students, a well-recognized advantage in delivering any kind of health care to adolescents. This accessibility is also important for the health care staff, who can locate the students easily when follow-up and compliance are important. In addition, the close, trusting relationship that typically develops between school-based health center staff and individual adolescents is critical to the success of efforts to provide effective health care to teens.

One important lesson our experience teaches is that the community may not immediately accept measures that make good public health sense. Extensive education of all involved, including community members, elected officials, and religious groups as well as all pertinent staff (who might not be knowledgeable about the proposed intervention), is essential to the successful and smooth implementation of controversial policies. The lead time necessary for doing this important groundwork is rarely appreciated by funders or program managers as a sound investment.

There is a real need for affected communities to be in on the development of public health policies from the beginning, playing a major role in identifying the community's important health problems, suggesting intervention strategies, and working with health experts to implement them. However, any progressive public health initiative, from family planning to violence and substance abuse

prevention, is likely to arouse opposition; fear and anger may make rational discourse difficult. If progress is ever to be made against the major public health and social problems affecting us, public health leaders must be willing to stand up to confrontation and to point out ignorance and misconceptions.

Although some public health advances in the past were controversial (e.g., fluoridation of public water supplies), many were less so, in part because they primarily dealt strictly with health issues. For example, many of the epidemic diseases of the past were curtailed or eradicated either by simple changes in hygiene or by the introduction of effective antibiotics. In contrast, many of today's public health initiatives are controversial because they attempt to address issues that are both social and medical in nature. As an example, the Norplant issue touches on adolescent sexuality and the social and ethical questions of coercion vs choice.

In addition, Norplant raises concerns in some about genocide or selective use. Because some minority communities distrust the health care system, they view Norplant as a means of controlling certain populations. The negative consequences of the infamous Tuskeegee syphilis study on the practice of public health cannot be overestimated; the study's strong repercussions in the Black community continue today.

Consequently, with any public health initiative that might be perceived as having a disproportionate impact on minorities (another example would be needle exchange programs for intravenous drug users), public health practitioners must educate the affected community about the scope of the problem and about the specific initiative as a potential solution. How this is done depends on the specific locale. First, local public health practitioners need to know their community and which community leaders must be involved. In Baltimore, for example, religious leaders and their organizations are very influential forces in the city. With the Norplant issue, the opinions of teachers and principals of the affected schools must be considered. Obviously, parents of adolescents in the schools must also be involved. In addition, formal and informal leaders should be sought out and involved: recreation center directors, school volunteers, neighborhood librarians—all those who have grassroots knowledge of the needs and perceptions of the community. It is with the involvement of all these members of a community that the likelihood of successful implementation of progressive, controversial public health policies will be the greatest. □

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APPENDIX—Opposition Claims and Baltimore City Health Department Responses about the Health Department's School-Based Norplant Policy

Opposition Claim	Health Department Response
Targeting inner-city African-American teens is genocide.	The policy is simply one of equity: making all contraceptives available in school-based health centers to those who would not otherwise be able to get them.
Insufficient testing of Norplant has been done on African-American adolescents.	(1) Food and Drug Administration trials of Norplant did include similar populations in Newark and San Francisco. (2) Norgestrel (the hormone found in Norplant) has been used in oral contraceptives by hundreds of thousands of African-American adolescents over the past 25 years, with no known differences in efficacy or side effects from those experienced by the rest of the population.
The new policy will lead to higher rates of sexually transmitted diseases and HIV infections in teenaged Norplant users because they will feel protected against pregnancy and will thus neglect to use condoms.	(1) The students will receive extensive counseling on the importance of condom use in conjunction with Norplant. (2) Norplant recipients in the first school-based site will be evaluated to ascertain the efficacy of this counseling.
The health department is promoting Norplant and sexual promiscuity over abstinence.	Abstinence is the only method of contraception that the health department promotes; the school system also has an abstinence curriculum. Norplant is simply another contraceptive option available to sexually active teenagers in the school-based health centers.
Norplant has dangerous side effects.	Norplant's side effects are primarily "nuisance" side effects; a stringent follow-up protocol will be observed to identify patients who need to have the implant removed or who need further counseling about side effects.
The program excludes families from adolescents' decisions about contraception.	Families are strongly encouraged to be present both for counseling sessions and for the actual insertion procedure.

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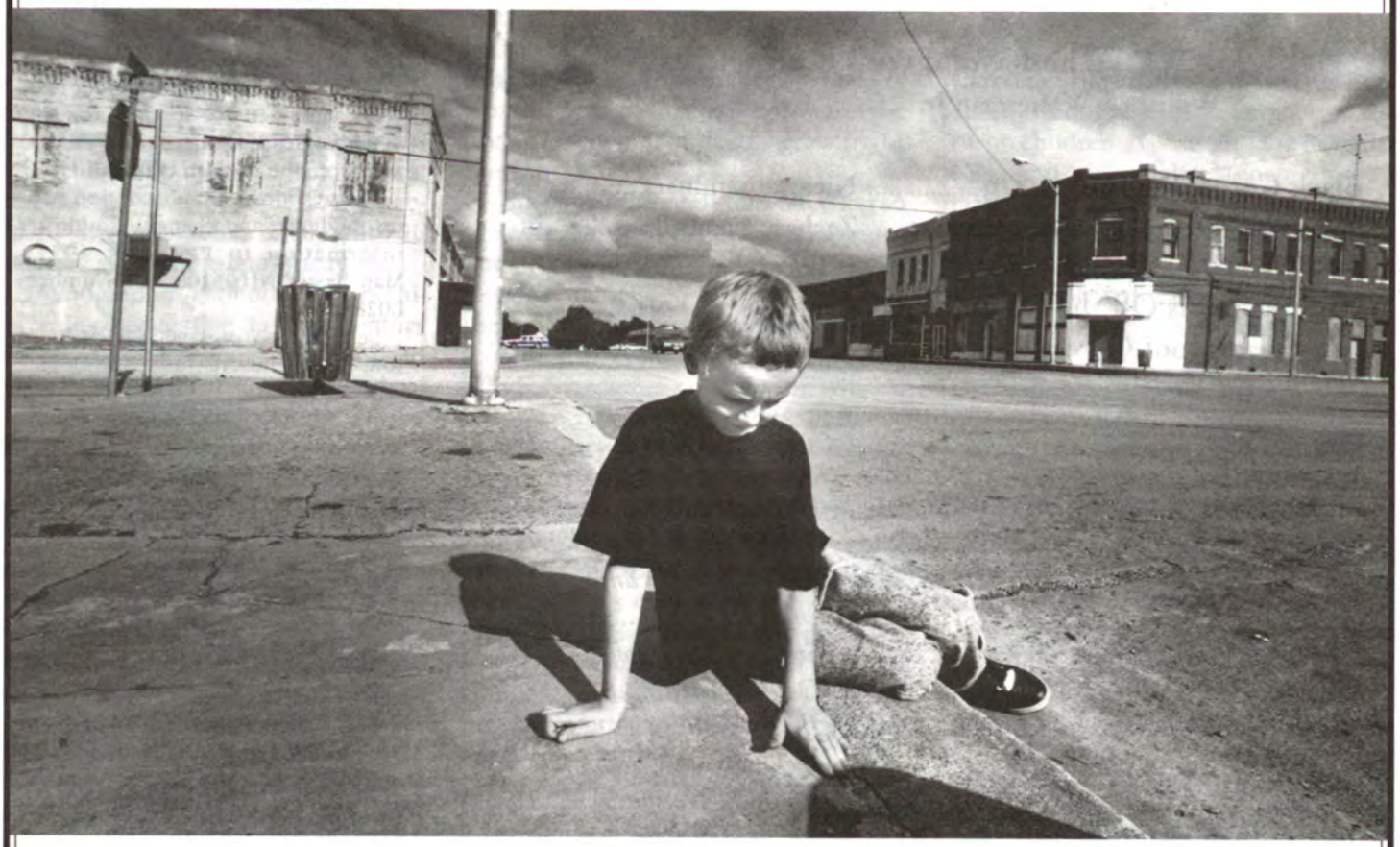

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