HB
375
File 2

March 24, 1998

I am writing in support of HB 375, the Smart Start initiative.

We read too much today in all our newspapers about Alaska's children not measuring up. Many of these kids have the potential to do the job you're doing today. Without the support of programs that will be supported by Smart Start, many of those same kids don't have a chance.

Sure, they get to go to school, but they don't go to school ready to learn. They get sick more often, they go without good meals, they live in homes where violence is the norm.

GIVE THEM A BREAK! Thanks for supporting HB 375.

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March 24, 1998

TO WHOM IT MAY CONCERN:

Try to imagine a world where every child grows up in a safe and nurturing environment. Try to imagine it even just for Alaska. It's a possibility, but only if we begin caring today about the fate of children in every family, in every community, across our state.

The SMART START initiatives for Alaska's families are a *smart* way to insure that children in our state remain a focus of prevention efforts. Alaska's kids depend on your support of HB 375. DO IT!

Thank you .

Carol H Brice

Carol H. Brice, RN, MEd.

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Lauterbach
3/23/98

CS FOR HOUSE BILL NO. 375( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to children in need of aid matters and proceedings; relating to child abuse and neglect; relating to murder of children, kidnapping, criminal nonsupport, the crime of indecent exposure, and the crime of endangering the welfare of a child; relating to sentencing for certain crimes involving child victims; relating to the state medical examiner and reviews of child fatalities; relating to teacher certification and convictions of crimes involving child victims; relating to access, confidentiality, and release of certain information concerning the care of children, child abuse and neglect, and child fatalities; authorizing the Department of Health and Social Services to enter into an interstate compact concerning adoption and medical assistance for certain children with special needs; relating to the review of cases involving certain children who are in the custody of the state; authorizing the establishment of multidisciplinary child protection teams;

relating to liability for actions concerning matters involving child protection and fatality reviews and children in need of aid; relating to persons required to report suspected child abuse or neglect; relating to foster care placement and foster care licensing; relating to access to certain criminal justice information and licensure of certain child care facilities; amending Rule 218, Alaska Rules of Appellate Procedure; amending the Alaska Child in Need of Aid Rules; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** INTENT AND PURPOSE OF ACT. (a) The intent of this Act is to protect children from abuse and neglect without prohibiting the use of reasonable methods of parental discipline or prescribing a particular method of parenting.

(b) The purpose of this Act is to

(1) provide the legal mechanisms by which the state can use its resources to implement the findings in this section for the best interest of children in this state; and

(2) expressly override the court decisions in the following cases:

(A) In Re S.A., 912 P.2d 1235 (Alaska 1996), and F.T. v. State, 862 P.2d 857 (Alaska 1993), concerning the standards to adjudicate a child in need of aid when a parent or caregiver is willing, but unable, to provide essential care for a child;

(B) A.M. v. State, 891 P.2d 815 (Alaska 1995), and Nada A. v. State, 660 P.2d 436 (Alaska App. 1983), concerning the standards to terminate parental rights when a parent is incarcerated;

(C) R.J.M. v. State, 946 P.2d 855 (Alaska 1997), concerning the type of neglect necessary to adjudicate a child in need of aid under AS 47.10.

* **Sec. 2.** AS 10.06.961(a) is amended to read:

(a) Notwithstanding AS 13.46.085 or the appointment of a guardian of the property of the **child** [MINOR] under **AS 47.10.010** [AS 47.10.010(c)], when a **child** [MINOR] who is in the custody of this state under AS 47.10 or **a minor who is in the custody of this state under** AS 47.12 or of another state under a provision similar to

AS 47.10 or AS 47.12 becomes entitled to receive dividends or other distributions resulting from the ownership of stock or a membership in a corporation organized under this chapter and under 43 U.S.C. 1601 - 1641 (Alaska Native Claims Settlement Act), the corporation paying the dividends or making the other distributions shall retain the dividends and other distributions in an interest bearing account for the benefit of the **child** [MINOR] during the state custody.

* **Sec. 3.** AS 11.41.100(a) is amended to read:

(a) A person commits the crime of murder in the first degree if

(1) with intent to cause the death of another person, the person

(A) causes the death of any person; or

(B) compels or induces any person to commit suicide through duress or deception; or

(2) the person knowingly engages **in conduct directed toward** [, UNDER CIRCUMSTANCES MANIFESTING EXTREME INDIFFERENCE TO THE VALUE OF HUMAN LIFE, IN A PATTERN OR PRACTICE OF ASSAULT OR TORTURE OF] a child under the age of 16, and [ONE OF THE ACTS OF ASSAULT OR TORTURE RESULTS IN THE DEATH OF THE CHILD; FOR PURPOSES OF THIS PARAGRAPH, A PERSON "ENGAGES IN A PATTERN OR PRACTICE OF ASSAULT OR TORTURE" IF] the person **with criminal negligence causes** [INFLICTS] serious physical injury to the child by at least two separate acts, and one of the acts results in the death of the child**; or**

(3) the person with criminal negligence causes the death of a child under the age of 16 during the course of committing or attempting to commit sexual assault in the first degree, sexual abuse of a minor in the first degree, or kidnapping.

* **Sec. 4.** AS 11.41.110(a) is amended to read:

(a) A person commits the crime of murder in the second degree if

(1) with intent to cause serious physical injury to another person or knowing that the conduct is substantially certain to cause death or serious physical injury to another person, the person causes the death of any person;

(2) the person knowingly engages in conduct that results in the death

of another person under circumstances manifesting an extreme indifference to the value of human life;

(3) acting either alone or with one or more persons, the person commits or attempts to commit arson in the first degree, kidnapping, sexual assault in the first degree, sexual assault in the second degree, burglary in the first degree, escape in the first or second degree, robbery in any degree, or misconduct involving a controlled substance under AS 11.71.010(a), 11.71.020(a), 11.71.030(a)(1) or (2), or 11.71.040(a)(1) or (2) and, in the course of or in furtherance of that crime, or in immediate flight from that crime, any person causes the death of a person other than one of the participants; [OR]

(4) acting with a criminal street gang, the person commits or attempts to commit a crime that is a felony and, in the course of or in furtherance of that crime or in immediate flight from that crime, any person causes the death of a person other than one of the participants; **or**

(5) the person with criminal negligence causes the death of a child under the age of 16, and the person has been previously convicted of a crime involving a child under the age of 16 that was

(A) in violation of AS 11.41;

(B) in violation of a law or ordinance in another jurisdiction with elements similar to a crime under AS 11.41; or

(C) an attempt, a solicitation, or a conspiracy to commit a crime listed in (A) or (B) of this paragraph in violation of AS 11.41 or of a law or ordinance in another jurisdiction with similar elements.

* Sec. 5. AS 11.41.300(a) is amended to read:

(a) A person commits the crime of kidnapping if

(1) the person restrains another with intent to

(A) hold the restrained person for ransom, reward, or other payment;

(B) use the restrained person as a shield or hostage;

(C) inflict physical injury upon or sexually assault the restrained person or place the restrained person or a third person in apprehension that any

person will be subjected to serious physical injury or sexual assault;

(D) interfere with the performance of a governmental or political function;

(E) facilitate the commission of a felony or flight after commission of a felony; [OR]

(F) commit an offense in violation of AS 11.41.434 - 11.41.438 upon the restrained person or place the restrained person or a third person in apprehension that a person will be subject to an offense in violation of AS 11.41.434 - 11.41.438; or

(2) the person restrains another

(A) by secreting and holding the restrained person in a place where the restrained person is not likely to be found; or

(B) under circumstances which expose the restrained person to a substantial risk of serious physical injury.

• **Sec. 6.** AS 11.41.300(d) is amended to read:

(d) In a prosecution for kidnapping, it is an affirmative defense which reduces the crime to a class A felony that the defendant voluntarily caused the release of the victim alive in a safe place before arrest, or within 24 hours after arrest, without having caused serious physical injury to the victim and without having engaged in conduct described in AS 11.41.410(a), [OR] 11.41.420, **11.41.434, or 11.41.436**.

• **Sec. 7.** AS 11.41 is amended by adding a new section to read:

Sec. 11.41.458. Indecent exposure in the first degree. (a) An offender commits the crime of indecent exposure in the first degree if

(1) the offender violates AS 11.41.460(a);

(2) while committing the act constituting the offense, the offender knowingly masturbates; and

(3) the offense occurs within the observation of a person under 16 years of age.

(b) Indecent exposure in the first degree is a class C felony.

• **Sec. 8.** AS 11.41.460 is amended to read:

Sec. 11.41.460. Indecent exposure in the second degree. (a) An offender

commits the crime of indecent exposure <u>in the second degree</u> if the offender intentionally exposes the offender's genitals to another person with reckless disregard for the offensive, insulting, or frightening effect the act may have on that person.

(b) Indecent exposure <u>in the second degree</u> before a person under 16 years of age is a class A misdemeanor. Indecent exposure <u>in the second degree</u> before a person 16 years of age or older is a class B misdemeanor.

* Sec. 9. AS 11.51.100 is repealed and reenacted to read:

Sec. 11.51.100. Endangering the welfare of a child in the first degree. (a) A person commits the crime of endangering the welfare of a child in the first degree if, being a parent, guardian, or other person legally charged with the care of a child, the person

(1) fails to provide adequate supervision of the child under circumstances creating a substantial risk of physical injury to the child;

(2) leaves the child with another person who is not a parent, guardian, or lawful custodian of the child knowing that the person

(A) is registered or required to register as a sex offender under AS 12.63 or a law or ordinance in another jurisdiction with similar requirements;

(B) has been charged by complaint, information, or indictment with a violation of AS 11.41.410 - 11.41.455 or a law or ordinance in another jurisdiction with similar elements; or

(C) has been charged by complaint, information, or indictment with an attempt, solicitation, or conspiracy to commit a crime described in (B) of this paragraph; or

(3) leaves the child with another person knowing that the person has previously physically mistreated or had sexual contact with any child, and the other person causes physical injury or engages in sexual contact with the child.

(b) In this section, "physically mistreated" means

(1) having committed an act punishable under AS 11.41.210 - 11.41.250; or

(2) having applied force to a child that, under the circumstances in

which it was applied, or considering the age or physical condition of the child, constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation because of the substantial and unjustifiable risk of

(A) death;

(B) serious or protracted disfigurement;

(C) protracted impairment of health;

(D) loss or impairment of the function of a body member or organ;

(E) substantial skin bruising, burning, or other skin injury;

(F) internal bleeding or subdural hematoma;

(G) bone fracture; or

(H) prolonged or extreme pain, swelling, or injury to soft tissue.

(c) Endangering the welfare of a child in the first degree under (a)(1) or (2) of this section is a class C felony.

(d) Endangering the welfare of a child in the first degree under (a)(3) of this section is a

(1) class B felony if the child dies;

(2) class C felony if the child suffers sexual contact or serious physical injury; or

(3) class A misdemeanor if the child suffers physical injury.

* **Sec. 10.** AS 11.51 is amended by adding new sections to read:

Sec. 11.51.110. Endangering the welfare of a child in the second degree. (a) A person commits the crime of endangering the welfare of a child in the second degree if, being a parent, guardian, or other person legally charged with the care of a child, the person

(1) while caring for the child, knowingly possesses a controlled substance that is not prescribed by a licensed health care practitioner;

(2) while caring for the child, abuses a controlled substance that is prescribed by a licensed health care practitioner; or

(3) while caring for the child, is incapacitated by alcohol or a controlled substance; in this paragraph, "incapacitated by alcohol or a controlled substance" means

that a person, as result of alcohol or a controlled substance, or both, is unconscious, or the person's judgment is so impaired that the person is incapable of making rational decisions with respect to the basic safety or personal needs of a child.

(b) Endangering the welfare of a child in the second degree is a violation.

Sec. 11.51.115. Criminal nonsupport in the first degree. (a) A person commits the crime of criminal nonsupport in the first degree if

(1) after administrative or court proceedings for a determination of an obligation under a support order are initiated involving the person, the person knowingly conveys assets, property, or another thing of value to another person in order to avoid payment of the support that may be ordered or has been ordered by the administrative agency or court; or

(2) the person is an obligor under a support order under AS 25.27 and without lawful excuse has failed to pay support to an extent that over $30,000 of arrearages have accrued, not including interest and penalties.

(b) In this section, "support order" has the meaning given in AS 25.27.900.

(c) Criminal nonsupport in the first degree is a class C felony.

* **Sec. 11.** AS 11.51.120(a) is amended to read:

(a) A person commits the crime of criminal nonsupport **in the second degree** if, being a person legally charged with the support of a child under 18 years of age, the person fails without lawful excuse to provide support for the child.

* **Sec. 12.** AS 11.51.120(c) is amended to read:

(c) Criminal nonsupport **in the second degree** is a class A misdemeanor.

* **Sec. 13.** AS 12.55.025(i) is amended to read:

(i) Except as provided by AS 12.55.125(a)(3), **12.55.125(k)(2)** [12.55.125(k)], 12.55.145(d), 12.55.155(f), and 12.55.165, the preponderance of the evidence standard of proof applies to sentencing proceedings.

* **Sec. 14.** AS 12.55.125(c) is amended to read:

(c) A defendant convicted of a class A felony may be sentenced to a definite term of imprisonment of not more than 20 years [.] and shall be sentenced to the following presumptive terms, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(1) if the offense is a first felony conviction and does not involve circumstances described in (2) of this subsection, five years;

(2) if the offense is a first felony conviction

(A) [,] other than for manslaughter [,] and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury during the commission of the offense, or knowingly directed the conduct constituting the offense at a uniformed or otherwise clearly identified peace officer, fire fighter, correctional employee, emergency medical technician, paramedic, ambulance attendant, or other emergency responder who was engaged in the performance of official duties at the time of the offense, seven years;

(B) for manslaughter and the victim is a child under the age of 16, seven years;

(3) if the offense is a second felony conviction, 10 years;

(4) if the offense is a third felony conviction and the defendant is not subject to sentencing under (1) of this section, 15 years.

*** Sec. 15.** AS 12.55.125(k) is amended to read:

(k) A first felony offender convicted of an offense for which a presumptive term of imprisonment is not specified under this section

(1) may be sentenced to a term of unsuspended imprisonment that exceeds the presumptive term of a second or third felony offender convicted of the same crime if the offender is convicted of criminally negligent homicide and the victim is a child under the age of 16;

(2) except as provided in (1) of this subsection, may not be sentenced to a term of unsuspended imprisonment that exceeds the presumptive term for a second felony offender convicted of the same crime unless the court finds by clear and convincing evidence that an aggravating factor under AS 12.55.155(c) is present, or that circumstances exist that would warrant a referral to the three-judge panel under AS 12.55.165.

*** Sec. 16.** AS 12.65.005(a) is amended to read:

(a) Unless the person has reasonable grounds to believe that notice has already

been given, a person who attends a death or has knowledge of a death, in addition to notifying a peace officer, shall immediately notify the state medical examiner when the death appears to have

(1) been caused by unknown or criminal means, during the commission of a crime, or by suicide, accident, or poisoning;

(2) occurred under suspicious or unusual circumstances or occurred suddenly when the decedent was in apparent good health;

(3) been unattended by a practicing physician or occurred less than 24 hours after the deceased was admitted to a medical facility;

(4) been associated with a diagnostic or therapeutic procedure;

(5) resulted from a disease that constitutes a threat to public health;

(6) been caused by a disease, injury, or toxic agent resulting from employment;

(7) occurred in a jail or corrections facility owned or operated by the state or a political subdivision of the state or in a facility for the placement of persons in the custody or under the supervision of the state;

(8) occurred in a foster home;

(9) occurred in a mental institution or mental health treatment facility; [OR]

(10) occurred while the deceased was in the custody of, or was being taken into the custody of, the state or a political subdivision of the state or a public officer or agent of the state or a political subdivision of the state; **or**

(11) been of a child under 18 years of age or under the legal custody of the Department of Health and Social Services, subject to the jurisdiction of AS 47.10 or AS 47.12, unless the

(A) child's death resulted from a natural disease process and was medically expected; and

(B) the child was under supervised medical care during the 24 hours before the death.

* **Sec. 17.** AS 12.65.015 is amended by adding a new subsection to read:

(e) The state medical examiner may appoint local, regional, and district child

fatality review teams to assist local, regional, and district medical examiners in determining the cause and manner of deaths of children under 18 years of age. If a team is appointed under this section, the team shall have the same access to information, confidentiality requirements, and immunity as provided to the state child fatality review team under AS 12.65.140. A meeting of a team appointed under this subsection is closed to the public and not subject to the provisions of AS 44.62.310 and 44.62.312. A review by a local, regional, or district child fatality review team does not relieve the state child fatality review team under AS 12.65.120 of the responsibility for reviewing these deaths under AS 12.65.130. A person appointed to a local, regional, or district child fatality review team is not eligible to receive compensation from the state for service on the team, but the person is eligible for travel expenses and per diem under AS 39.20.180. A person appointed to a team under this subsection serves at the pleasure of the state medical examiner.

* **Sec. 18.** AS 12.65 is amended by adding new sections to read:

Sec. 12.65.120. State child fatality review team. (a) The state child fatality review team is established in the Department of Health and Social Services to assist the state medical examiner. The team is composed of

(1) the following persons, or that person's designee:

(A) the state medical examiner;

(B) a state prosecutor with experience in homicide prosecutions, appointed by the attorney general;

(C) an investigator with the state troopers who has experience in conducting investigations of homicide, child abuse, or child neglect, appointed by the commissioner of public safety;

(D) a social worker with the Department of Health and Social Services who has experience in conducting investigations of child abuse and neglect, appointed by the commissioner of health and social services;

(2) the following persons, or that person's designee, appointed by the commissioner of health and social services:

(A) a physician licensed under AS 08.64 who

(i) specializes in neonatology or perinatology; or

(ii) is certified by the American Board of Pediatrics;

(B) a municipal law enforcement officer with experience in conducting investigations of homicide, child abuse, or child neglect;

(C) other persons whose experience and expertise would, as determined by the commissioner of health and social services, contribute to the effectiveness of the team.

(b) A team member is not eligible to receive compensation from the state for service on the team. A member appointed under (a)(2) of this section

(1) is eligible for travel expenses and per diem under AS 39.20.180; and

(2) serves at the pleasure of the commissioner of health and social services.

(c) In addition to the persons specified in (a) and (b) of this section, the team may invite a person to participate as a member of the team if the person has expertise that would be helpful to the team in a review of a specific death. A person participating under this subsection is eligible only for travel expenses and per diem under AS 39.20.180.

(d) The state medical examiner serves as chair of the team.

Sec. 12.65.130. State child fatality review team duties. The state child fatality review team shall review deaths of children in state custody and upon request of a law enforcement agency. The team shall

(1) assist the state medical examiner in determining the cause and manner of the deaths of children in state custody under 18 years of age;

(2) unless the child's death is currently being investigated by a law enforcement agency, review any report of a death of a child within 48 hours of the report being received by the medical examiner if

(A) the death is of a child under 10 years of age,

(B) the deceased child, a sibling, or a member of the deceased child's household

(i) is in the legal or physical custody of the state under AS 47, or under similar custody of another state or political subdivision of a state; or

(ii) has been the subject of a report of harm under AS 47.17, or a child abuse or neglect investigation by the Department of Health and Social Services or by a similar child protective service in this or another state;

(C) a protective order under AS 18.66.100 or 18.66.110 has been in effect during the previous year in which the petitioner or respondent was a member of the deceased child's immediate family or household; or

(D) the child's death occurred in a mental health institution, mental health treatment facility, foster home, or other residential or child care facility, including a day care facility;

(3) review records concerning

(A) abuse or neglect of the deceased child or another child in the deceased child's household;

(B) the criminal history or juvenile delinquency of a person who may have caused the death of the child and of persons in the deceased child's household; and

(C) a history of domestic violence involving a person who may have caused the death of the child or involving persons in the deceased child's household, including records in the central registry of protective orders under AS 18.65.540;

(4) if a local, regional, or district child fatality review team has not been appointed under AS 12.65.015 or is not available, be available to provide recommendations, suggestions, and advice to state or municipal law enforcement agencies in the investigation of deaths of children.

Sec. 12.65.140. Records; information; meetings; confidentiality. (a) The state child fatality review team and its members shall have access to all information and records to which the state medical examiner has access under this chapter. The state child fatality review team and its members shall maintain the confidentiality of information and records concerning deaths under review, except when disclosures may be necessary to enable the team to carry out its duties under this chapter. However, the state child fatality review team and its members may not disclose a record that is

confidential under federal or state law.

(b) Except for public reports issued by the state child fatality review team, records and other information collected by the team or its members related to duties under this chapter are confidential and not subject to public disclosure under AS 09.25.100 - 09.25.220.

(c) Meetings of the state child fatality review team are closed to the public and are not subject to the provisions of AS 44.62.310 and 44.62.312.

* **Sec. 19.** AS 14.20.020(f) is amended to read:

(f) <u>The</u> [EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION, THE] department may not issue a teacher certificate to a person who has been convicted of a crime involving a minor under AS 11.41.434 - 11.41.440, 11.41.455, <u>11.41.458,</u> or 11.41.460, or under a law in another jurisdiction with elements substantially similar to an offense described in AS 11.41.434 - 11.41.440, 11.41.455, <u>11.41.458,</u> or 11.41.460<u>, or that is an attempt, solicitation, or conspiracy to commit a crime described in this subsection or a law or ordinance in another jurisdiction with similar elements</u>. [WHEN FIVE YEARS HAVE ELAPSED AFTER A PERSON HAS RECEIVED AN UNCONDITIONAL DISCHARGE FOR A CONVICTION OF A CRIME LISTED IN THIS SUBSECTION, THE PERSON MAY PETITION THE DEPARTMENT TO ISSUE THE CERTIFICATE IN SPITE OF THE CONVICTION IF THE PERSON OTHERWISE SATISFIES THE REQUIREMENTS FOR THE CERTIFICATE. WHEN DECIDING WHETHER TO GRANT OR DENY THE PETITION, THE DEPARTMENT SHALL CONSIDER THE NATURE OF THE PARTICULAR CRIME, WHETHER AND TO WHAT EXTENT THE PERSON HAS BEEN REHABILITATED, AND THE OTHER FACTORS THAT THE DEPARTMENT DETERMINES ARE SIGNIFICANT.]

* **Sec. 20.** AS 14.20.030(b) is amended to read:

(b) <u>Upon receipt of a judgment of conviction, the department</u> [THE COMMISSIONER OR THE PROFESSIONAL TEACHING PRACTICES COMMISSION] shall <u>permanently</u> revoke<u>, effective immediately,</u> [FOR LIFE] the certificate of a person who has been convicted of a crime involving a minor under AS 11.41.434 - 11.41.440, 11.41.455, <u>11.41.458,</u> or 11.41.460, or under a law in

another jurisdiction with elements substantially similar to an offense described in AS 11.41.434 - 11.41.440, 11.41.455, 11.41.458, or 11.41.460, or that is an attempt, solicitation, or conspiracy to commit a crime described in this subsection or a law or ordinance in another jurisdiction with similar elements. If the judgment of conviction is reversed on appeal and the person is otherwise eligible for licensure, the department shall reinstate the license. [WHEN FIVE YEARS HAVE ELAPSED AFTER THE PERSON HAS RECEIVED AN UNCONDITIONAL DISCHARGE FOR THE CONVICTION, THE PERSON MAY PETITION THE COMMISSION FOR RECERTIFICATION. WHEN DECIDING WHETHER TO GRANT OR DENY THE PETITION, THE COMMISSION SHALL CONSIDER THE NATURE OF THE PARTICULAR CRIME, WHETHER AND TO WHAT EXTENT THE PERSON HAS BEEN REHABILITATED, AND THE OTHER FACTORS THAT THE COMMISSION DETERMINES ARE SIGNIFICANT.]

* **Sec. 21.** AS 22.15.100 is amended to read:

Sec. 22.15.100. Functions and powers of district judge and magistrate. Each district judge and magistrate has the power

(1) to issue writs of habeas corpus for the purpose of inquiring into the cause of restraint of liberty, returnable before a judge of the superior court, and the same proceedings shall be had on the writ as if it had been granted by the superior court judge under the laws of the state in such cases;

(2) of a notary public;

(3) to solemnize marriages;

(4) to issue warrants of arrest, summons, and search warrants according to manner and procedure prescribed by law and the supreme court;

(5) to act as an examining judge or magistrate in preliminary examinations in criminal proceedings; to set, receive, and forfeit bail and to order the release of defendants under bail;

(6) to act as a referee in matters and actions referred to the judge or magistrate by the superior court, with all powers conferred upon referees by laws;

(7) of the superior court in all respects including but not limited to contempts, attendance of witnesses, and bench warrants;

(8) to order the temporary detention of a minor, or take other action authorized by law or rules of procedure, in cases arising under AS 47.10 [AS 47.10.010 - 47.10.142] or AS 47.12, when the minor is in a condition or surrounding dangerous or injurious to the welfare of the minor or others that requires immediate action; the action may be continued in effect until reviewed by the superior court in accordance with rules of procedure governing these cases;

(9) to issue a protective order in cases involving domestic violence as provided in AS 18.66.100 - 18.66.180;

(10) to review an administrative revocation of a person's driver's license or nonresident privilege to drive, and an administrative refusal to issue an original license, when designated as a hearing officer by the commissioner of administration and with the consent of the administrative director of the state court system;

(11) to establish the fact of death or inquire into the death of a person in the manner prescribed under AS 09.55.020 - 09.55.069.

* **Sec. 22.** AS 25.23.050(a) is amended to read:

(a) Consent to adoption is not required of

(1) for purposes of this section, a parent who has abandoned a child for a period of at least six months;

(2) a parent of a child in the custody of another [.] if the parent for a period of at least one year has failed significantly without justifiable cause, including but not limited to indigency,

(A) to communicate meaningfully with the child; [.] or

(B) to provide for the care and support of the child as required by law or judicial decree;

(3) the father of a minor if the father's consent is not required by AS 25.23.040(a)(2);

(4) a parent who has relinquished the right to consent under AS 25.23.180;

(5) a parent whose parental rights have been terminated by order of the court under AS 25.23.180(c)(3) or AS 47.10.080(c)(5) [AS 47.10.080(c)(3)];

(6) a parent judicially declared incompetent or mentally defective if the

court dispenses with the parent's consent;

(7) a parent of the person to be adopted [,] if the person is 19 or more years of age [,] and the court dispenses with the consent of the parent;

(8) a guardian or custodian specified in AS 25.23.040(a)(3) or (4) who has failed to respond in writing to a request for consent for a period of 60 days or who, after examination of the guardian's or custodian's written reasons for withholding consent, is found by the court to be withholding consent unreasonably; or

(9) the spouse of the person to be adopted [,] if the requirement of consent to the adoption is waived by the court by reason of prolonged unexplained absence, unavailability, incapacity, or circumstances constituting an unreasonable withholding of consent.

* **Sec. 23.** AS 25.23.180(c) is amended to read:

(c) The relationship of parent and child may be terminated by a court order issued in connection with a proceeding under this chapter or a proceeding under AS 47.10 **on the grounds** [:]

(1) [ON THE GROUNDS] specified in **AS 47.10.080(o) or 47.10.088** [AS 47.10.080(c)(3)];

(2) [ON THE GROUNDS] that a parent who does not have custody is unreasonably withholding consent to adoption, contrary to the best interest of the minor child; or

(3) [ON GROUNDS] that the parent committed an act constituting sexual assault or sexual abuse of a minor under the laws of this state or a comparable offense under the laws of the state where the act occurred that resulted in conception of the child and that termination of the parental rights of the biological parent is in the best interests of the child.

* **Sec. 24.** AS 47.05 is amended by adding a new section to read:

Sec. 47.05.065. Legislative findings related to children. The legislature finds that

(1) it is the policy of the state to recognize that children are individuals who have legal rights; among those rights are the right to

(A) a safe and happy childhood;

(B) reasonable safety, adequate care, and adequate treatment;

(C) freedom from physical abuse, sexual abuse, exploitation, and substance abuse;

(D) special safeguards and care, including appropriate legal protection before as well as after birth;

(E) permanency with a safe, loving family;

(2) parents and guardians should make reasonable efforts to afford their children the rights listed in (1) of this section; parents and guardians should make reasonable efforts to remove any impediment that substantially impairs their ability to afford these rights to their children; and when a parent or guardian fails to make reasonable efforts to fulfill these responsibilities, the court may determine that it is in the best interests of this child to remove the child from the parent or guardian, either temporarily or permanently;

(3) it is the policy of the state to recognize that the purpose of this title and the services provided to families under this title is to protect children from child abuse and neglect and to preserve and strengthen the family and that

(A) except in those cases involving serious risk to a child's health or safety, the Department of Health and Social Services should make reasonable efforts to offer appropriate family support services that identify and provide to parents and guardians the necessary opportunities to adjust their circumstances, conduct, or conditions to prevent removal of a child from the home and, if the child is removed, to make return of the child possible so as to prevent termination of parental rights; and

(B) when a child is removed from the home, the department should make reasonable efforts to provide weekly supervised or unsupervised visitation between the child and the child's parent or guardian and extended family members unless the visitation would be harmful to the child;

(4) it is the policy of the state to recognize that, when a child is a ward of the state, the child is entitled to reasonable safety, adequate care, and adequate treatment and that the Department of Health and Social Services as legal custodian and the child's guardian ad litem as guardian of the child's best interests and their agents

and assignees, each should make reasonable efforts to ensure that the child is provided with reasonable safety, adequate care, and adequate treatment for the duration of time that the child is a ward of the state;

(5) it is in the best interests of a child who has been removed from the child's own home for the state to apply the following principles in resolving the situation:

(A) the child should be placed in a safe, secure, and stable environment;

(B) the child should not be moved unnecessarily;

(C) a planning process should be followed to lead to permanent placement of the child;

(D) every effort should be made to encourage psychological attachment between the adult caregiver and the child; and

(E) immediate and regular visitation between the child and the child's parent or guardian and extended family members should be encouraged;

(6) parents and guardians have the right to direct the upbringing of their children, including their medical care and the right to exercise reasonable corporal discipline;

(7) parents and guardians should make reasonable efforts to actively participate in family support services so as to facilitate the child's being able to remain in the home; when children are removed from the home, the parents and guardians should actively participate in family support services to make return of their children to the home possible; and

(8) numerous studies establish that

(A) children undergo a critical attachment process before the time they reach six years of age;

(B) a child who has not attached with an adult caregiver during this critical stage will suffer significant emotional damage that frequently leads to chronic psychological problems and antisocial behavior when the child reaches adolescence and adulthood; and

(C) it is important to provide for an expedited placement

procedure to ensure that all children, especially those under the age of six years, who have been removed from their homes are placed in permanent homes expeditiously.

* **Sec. 25.** AS 47.05 is amended by adding a new section to read:

Sec. 47.05.090. Authorization of the Interstate Compact on Adoption and Medical Assistance. (a) The Department of Health and Social Services may, on behalf of the state, enter into the Interstate Compact on Adoption and Medical Assistance and supplementary agreements with agencies of other states for the provision of adoption and medical assistance under AS 47.07 and other provisions of this title for eligible children with special needs.

(b) In this section, "state" includes a state, territory, possession, or commonwealth of the United States.

* **Sec. 26.** AS 47.10 is amended by adding a new section to read:

Sec. 47.10.005. Construction. The provisions of this chapter shall be liberally construed to the end that a child coming within the jurisdiction of the court under this chapter may receive the care, guidance, treatment, and control that will promote the child's welfare.

* **Sec. 27.** AS 47.10.010 is repealed and reenacted to read:

Sec. 47.10.010. Jurisdiction. (a) Proceedings relating to a child under 18 years of age residing or found in the state are governed by this chapter, except as otherwise provided in this chapter, when the child is alleged to be or may be determined by the court to be a child in need of aid under AS 47.10.011

(b) In a controversy concerning custody of a child under this chapter, the court may appoint a guardian of the person and property of a child, may appoint an attorney to represent the legal interests of the child, and may order support from either or both parents. Custody of a child may be given to the department and payment of support money to the department may be ordered by a court.

* **Sec. 28.** AS 47.10 is amended by adding new sections to read:

Sec. 47.10.011. Children in need of aid. Subject to AS 47.10.019, the court may find a child to be a child in need of aid if it finds by a preponderance of the evidence that the child has been subjected to any of the following:

(1) the parent or guardian has abandoned the child as described in AS 47.10.013;

(2) a parent, guardian, or custodian is incarcerated;

(3) a custodian with whom the child has been left is unwilling or unable to provide care, supervision, or support for the child, and the whereabouts of the parent or guardian is unknown;

(4) the child is in need of medical treatment to cure, alleviate, or prevent substantial physical harm or is in need of treatment for mental injury, and the child's parent, guardian, or custodian has knowingly failed to provide the treatment;

(5) the child is habitually absent from home or refuses to accept available care and the child's conduct threatens the child's physical or emotional health or safety;

(6) the child has suffered substantial physical harm, or there is a substantial risk that the child will suffer substantial physical harm, as a result of conduct by or conditions created by the child's parent, guardian, or custodian or by the failure of the parent, guardian, or custodian to supervise the child adequately;

(7) the child has suffered sexual abuse, or there is a substantial risk that the child will suffer sexual abuse, as a result of conduct by or conditions created by the child's parent, guardian, or custodian or by the failure of the parent, guardian, or custodian to adequately supervise the child; if a parent, guardian, or custodian has actual notice that a person has been convicted of a sex offense against a minor within the past 15 years, is registered or required to register as a sex offender under AS 12.63, or is under investigation for a sex offense against a minor, and the parent, guardian, or custodian subsequently allows a child to be left with that person, this conduct constitutes prima facie evidence that the child is at substantial risk of being sexually abused;

(8) conduct by or conditions created by the parent, guardian, or custodian have subjected the child or another child in the same household to neglect;

(9) the parent, guardian, or custodian's ability to parent has been substantially impaired by the addictive or habitual use of intoxicants or controlled substances; the resumption of use of intoxicants or of a controlled substance by a

parent, guardian, or custodian after rehabilitation or a period of abstinence is prima facie evidence that the ability to parent is substantially impaired as described in this paragraph;

(10) the parent, guardian, or custodian has a mental illness, serious emotional disturbance, or mental deficiency of a nature and duration that has caused substantial physical harm to the child or creates a risk of substantial physical harm to the child;

(11) the child has committed an illegal act as a result of pressure, guidance, or approval from the child's parent, guardian, or custodian.

Sec. 47.10.013. Abandonment. For purposes of this chapter, the court may find abandonment of a child if a parent or guardian has shown a conscious disregard of parental responsibilities toward the child by failing to provide reasonable support, maintain regular contact, or provide normal supervision and the failure is accompanied by intention on the part of the parent or guardian to permit the failure to continue for an indefinite period. Abandonment of a child also includes instances when the parent or guardian, without justifiable cause,

(1) left the child with another person without provision for the child's support and without meaningful communication with the child for a period of three months;

(2) has made only minimal efforts to support and communicate with the child;

(3) failed for a period of at least six months to maintain regular visitation with the child;

(4) failed to participate in a suitable plan or program designed to reunite the parent or guardian with the child;

(5) left the child without affording means of identifying the child and the child's parent or guardian;

(6) failed to respond to notice of child protective proceedings; or

(7) was unwilling to provide care, support, or supervision for the child.

Sec. 47.10.014. Neglect. For purposes of this chapter, the court may find neglect of a child if the parent, guardian, or custodian fails to provide the child with

adequate food, clothing, shelter, education, medical attention, or other care and control necessary for the child's physical health and development, though financially able to do so or offered financial or other reasonable means to do so.

Sec. 47.10.015. Physical harm. For the purposes of this chapter, the court may find physical harm to a child or substantial risk of physical harm to a child if

(1) the child was the victim of an act described in AS 11.41.100 - 11.41.250, 11.41.300, 11.41.410 - 11.41.455, or AS 11.51.100 and the physical harm occurred as a result of conduct by or conditions created by a parent, guardian, or custodian; or

(2) a negligent act or omission by a parent, guardian, or custodian creates a substantial risk of injury to the child.

Sec. 47.10.019. Limitations on determinations. Notwithstanding other provisions of this chapter, the court may not find a minor to be a child in need of aid under this chapter solely on the basis that the child's family is poor, lacks adequate housing, or exhibits a lifestyle that is different from the generally accepted lifestyle standard of the community where the family lives. However, this section may not be construed to prevent a court from finding that a child is in need of aid if the child has been subjected to conduct or conditions described in AS 47.10.011 - 47.10.015.

* **Sec. 29.** AS 47.10.020(a) is amended to read:

(a) Whenever circumstances subject a **child** [MINOR] to the jurisdiction of **the court under AS 47.10.005 - 47.10.142** [AS 47.10.010 - 47.10.142], the court shall appoint a competent person or agency to make a preliminary inquiry and report for the information of the court to determine whether the **best** interests of the **child** [MINOR] require that further action be taken. **If** [; IF], under this subsection, the court appoints a person or agency to make a preliminary inquiry and to report to it, then, upon the receipt of the report, the court may

(1) close [INFORMALLY ADJUST] the matter without a **court** hearing;

(2) determine whether the best interests of the child require that further action be taken; [.] or

(3) [IT MAY] authorize the person **or agency** having knowledge of the facts of the case to file with the court a petition setting out the facts[; IF THE COURT

INFORMALLY ADJUSTS THE MATTER, THE MINOR MAY NOT BE DETAINED OR TAKEN INTO THE CUSTODY OF THE COURT AS A CONDITION OF THE ADJUSTMENT, AND THE MATTER SHALL BE CLOSED BY THE COURT UPON ADJUSTMENT].

* **Sec. 30.** AS 47.10.020(b) is amended to read:

(b) The petition and all subsequent pleadings shall be styled as follows: "In the matter of . . . . . ., a **child** [MINOR] under 18 years of age." The petition may be executed upon the petitioner's information and belief [,] and must be verified. It must include the following information:

(1) the name, address, and occupation of the petitioner, together with the petitioner's relationship to the **child** [MINOR], and the petitioner's interest in the matter;

(2) the name, age, and address of the **child** [MINOR];

(3) a brief statement of the facts that bring the **child** [MINOR] within this chapter;

(4) the names and addresses of the **child's** [MINOR'S] parents;

(5) **the tribal affiliation, if any, of the child;**

(6) the name and address of the **child's** [MINOR'S] guardian [,] or of the person having control or custody of the **child** [MINOR].

* **Sec. 31.** AS 47.10.050(a) is amended to read:

(a) Whenever in the course of proceedings instituted under this chapter it appears to the court that the welfare of a **child** [MINOR] will be promoted by the appointment of an attorney to represent the **child** [MINOR OR AN ATTORNEY OR OTHER PERSON TO SERVE AS GUARDIAN AD LITEM], the court may make the appointment. **If it appears to the court that the welfare of a child in the proceeding will be promoted by the appointment of an attorney or other person to serve as guardian ad litem, the court shall make the appointment.** Appointment of a guardian ad litem or attorney shall be made under the terms of AS 25.24.310.

* **Sec. 32.** AS 47.10.070(a) is amended to read:

(a) The court may conduct the hearing on the petition in an informal manner in the courtroom or in chambers. The court shall give notice of the hearing to the

department, the child's parents, and the child's guardian and guardian ad litem, if any [AND IT MAY SEND A REPRESENTATIVE TO THE HEARING]. The court shall also transmit a copy of the petition to the persons to whom the court must send notice of the hearing [DEPARTMENT]. The persons to whom the court must send notice of the hearing and assistants of those persons are entitled to [REPRESENTATIVE OF THE DEPARTMENT MAY ALSO] be heard at the hearing. The public shall be excluded from the hearing, but the court, in its discretion, may permit individuals, such as the child's health care providers, to attend a hearing if their attendance is compatible with the best interests of the child [MINOR].

* **Sec. 33.** AS 47.10.080(a) is amended to read:

(a) An adjudication hearing shall be completed within 120 days after a finding of probable cause is entered unless the court finds good cause to continue the hearing. The court, at the conclusion of the hearing, [OR THEREAFTER] as the circumstances of the case may require, shall find and enter a judgment that the child [MINOR] is or is not a child in need of aid.

* **Sec. 34.** AS 47.10.080(c) is amended to read:

(c) If the court finds that the child [MINOR] is a child in need of aid, the court [IT] shall

(1) order the child committed to the custody of the department for placement with the child's parent if the conditions of this paragraph are satisfied; if the finding that the child is a child in need of aid is based on actions of another person who lives with the child, the court shall consider whether the continued presence of the other person in the home presents a substantial risk of harm to the child and whether it would be in the child's best interest for the court to order the other person to leave the home and to allow the child to remain in the home; if the continued presence of the other person in the home presents a substantial risk of harm to the child and it is in the child's best interest for the court to issue an order requiring the other person to leave the home and allowing the child to remain in the home, the court shall do so; the order must be accompanied by findings on the record of why the continued presence of the other person in the home would present a substantial risk of harm to the child and why the order is

in the best interest of the child; the order must also include appropriate protective orders; the court may not let the child remain in a home under this paragraph and shall issue an order that complies with another paragraph of this subsection unless the court finds that conditions and care in the home after the other person has left will be adequate to safeguard the child from harm to the child's life, physical health, and mental well-being;

(2) if the court determines that a relative by blood or marriage has requested that the child be placed with the relative and that placement with the relative would be in the best interest of the child, the court shall order the child committed to the department for placement with the relative for a period of time not to exceed two years or, in any event, past the date the child becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court, upon a showing of exceptional circumstances, may grant in a hearing (A) one-year extensions of commitment that do not extend beyond the child's 19th birthday if the extensions are in the best interest of the child; and (B) an additional one-year period of state custody past age 19 if the continued state custody is in the best interest of the person and the person consents to it; if more than one relative requests placement of the child under this paragraph, the court shall give preference to a relative who can demonstrate compliance with the minimum standards of care for children established under AS 47.14.120; if the court orders the department to place a child with a relative under this paragraph, the court shall also order the department to submit to the court, within seven days after the child is placed with the relative, the results of a name-check criminal background investigation conducted by the department for all members of the relative's household who are 12 years of age or older and the results of an investigation as to whether any member of the relative's household who is 12 years of age or older has been the perpetrator in a substantiated report of abuse; for purposes of this paragraph, the department is a criminal justice agency conducting a criminal justice activity; the court shall also order the department to submit to the court, within 14 days after the child is placed with the relative, a home study of the relative's home; if the court determines that there is a household member

12 years of age or older who has a criminal record or a history of committing abuse, the court shall order the department to remove the child from the household within 24 hours and place the child in licensed foster care, except that the court may continue the child's placement in the relative's household if the criminal record and history of committing abuse does not include any felonies; if the court determines from the home study that the child should be removed from the relative's home, the court shall promptly order the department to remove the child from the household within 24 hours and place the child in licensed foster care;

(3) order the child [MINOR] committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event past the date the child [MINOR] becomes 19 years of age, except that the department or the child's guardian ad litem may petition for and the court, upon a showing of exceptional circumstances, may grant in a hearing (A) one-year [TWO-YEAR] extensions of commitment that do not extend beyond the child's [MINOR'S] 19th birthday if the extension is in the best interests of the child [MINOR]; and (B) an additional one-year period of state custody [SUPERVISION] past age 19 if the continued state custody [SUPERVISION] is in the best interests of the person and the person consents to it; the department may transfer the child [MINOR], in the child's [MINOR'S] best interests, from one placement setting to another, and the child [MINOR], the child's [MINOR'S] parents or guardian, the child's foster parents or out-of-home relative caregiver, the child's health care providers, the child's guardian ad litem, [AND] the child's [MINOR'S] attorney , and the child's tribe, if any, are entitled to reasonable notice of the transfer;

(4) [(2)] order the child [MINOR] released to a parent, relative, or guardian of the child [THE MINOR'S PARENTS, GUARDIAN,] or to another [SOME OTHER] suitable person, and, in appropriate cases, order the parent, relative [PARENTS], guardian, or other person to provide medical or other care and treatment; if the court releases the child [MINOR], it shall direct the department to supervise the care and treatment given to the child [MINOR], but the court may dispense with the department's supervision if the court finds that the adult to whom the child [MINOR]

is released will adequately care for the **child** [MINOR] without supervision; the department's supervision may not exceed two years or in any event extend past the date the **child** [MINOR] reaches age 19, except that the department **or the child's guardian ad litem** may petition for and the court, **upon a showing of exceptional circumstances,** may grant in a hearing

(A) **one-year** [TWO-YEAR] extensions of supervision that do not extend beyond the **child's** [MINOR'S] 19th birthday if the **extensions are** [EXTENSION] is in the best interests of the **child** [MINOR]; and

(B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; or

(5) [(3) BY] order, **under the grounds specified in (o) of this section or AS 47.10.088, the termination of** [UPON A SHOWING IN THE ADJUDICATION BY CLEAR AND CONVINCING EVIDENCE THAT THERE IS A CHILD IN NEED OF AID UNDER AS 47.10.010(a) AS A RESULT OF PARENTAL CONDUCT AND UPON A SHOWING IN THE DISPOSITION BY CLEAR AND CONVINCING EVIDENCE THAT THE PARENTAL CONDUCT IS LIKELY TO CONTINUE TO EXIST IF THERE IS NO TERMINATION OF PARENTAL RIGHTS, TERMINATE] parental rights and responsibilities of one or both parents [,] and commit the child to the **custody of the** department [OR TO A LEGALLY APPOINTED GUARDIAN OF THE PERSON OF THE CHILD], and the department [OR GUARDIAN] shall report **quarterly** [ANNUALLY] to the court on efforts being made to find a permanent placement for the child.

* **Sec. 35.** AS 47.10.080(d) is amended to read:

(d) An order issued under **(c)(5)** [(c)(3)] of this section authorizes the commissioner of health and social services or a designee or the guardian of the person of the child to consent to the adoption of the child.

* **Sec. 36.** AS 47.10.080(f) is amended to read:

(f) A **child** [MINOR] found to be a child in need of aid is a ward of the state while committed to the department or the department has the power to supervise the **child's** [MINOR'S] actions. **After the permanency hearing required by (l) of this**

section, the [THE] court shall review an order made under (c)(2) - (4) [(c)(1) or (2)] of this section annually, and may review the order more frequently, to determine if continued placement or supervision, as it is being provided, is in the best interest of the child [MINOR. IF ANNUAL REVIEW UNDER THIS SUBSECTION WOULD ARISE WITHIN 90 DAYS OF THE HEARING REQUIRED UNDER (l) OF THIS SECTION, THE COURT MAY POSTPONE REVIEW UNDER THIS SUBSECTION UNTIL THE TIME SET FOR THE HEARING]. The department, the child, and [MINOR], the child's [MINOR'S] parents, guardian, foster parents, child health care providers, and guardian ad litem [OR CUSTODIAN] are entitled, when good cause is shown, to a review on application. If the application is granted, the court shall afford these persons [PARTIES] and their counsel or other representative reasonable notice in advance of the review and hold a hearing where these persons [PARTIES] and their counsel or other representative shall be afforded an opportunity to be heard. The child [MINOR] shall be afforded the opportunity to be present and to be heard at the review.

* **Sec. 37.** AS 47.10.080(i) is amended to read:

(i) A child or [MINOR,] the child's [MINOR'S] parents, [OR] guardian, guardian ad litem, foster parent, relative with whom the child is living, or attorney, acting on the child's [MINOR'S] behalf, or the department may appeal a judgment or order, or the stay, modification, setting aside, revocation, or enlargement of a judgment or order issued by the court under this chapter. Absent extraordinary circumstances, a decision on the appeal shall be issued no later than 90 days after the latest of the following:

(1) the date oral argument, if any, is heard on the appeal; or

(2) the date oral argument would have been heard under applicable court rules if oral argument had been timely requested.

* **Sec. 38.** AS 47.10.080(l) is amended to read:

(l) Within 12 [18] months after the date the child enters foster care as calculated under AS 47.10.088(f) [A CHILD IS INITIALLY REMOVED FROM THE CHILD'S HOME BY THE DEPARTMENT UNDER AS 47.10.142(c)] or is committed to the custody of the department under (c)(2), (3), or (5) [(c)(1) or (3)] of this section

or AS 47.14.100(c), the court shall hold a **permanency** hearing to review the placement and services provided and to determine the future status of the **child. The persons entitled to be heard at the hearing under AS 47.10.070 or under (f) of this section are also entitled to be heard at the hearing under this subsection** [MINOR]. The court shall make appropriate written findings, including findings related to the following:

(1) whether the parent or guardian has made substantial progress to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(2) whether the child should be returned to the parent **or guardian**;

(3) [(2)] whether the child should remain in out-of-home care for a specified period;

(4) [(3)] whether the child should remain in out-of-home care on a permanent or long-term basis because of special needs or circumstances;

(5) [(4)] whether the child should be placed for adoption or legal guardianship;

(6) whether the department has made reasonable efforts to offer appropriate family support services to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter.

* **Sec. 39.** AS 47.10.080(o) is amended to read:

(o) For purposes of terminating a parent's parental rights under **(c)(5)** [THE STANDARDS IN (c)(3)] of this section, the court may determine that incarceration of the parent is sufficient grounds for determining that a **child** [MINOR] is a child in need of aid under **AS 47.10.011** [AS 47.10.010(a)(1)] as a result of parental conduct and that the **parental rights of the incarcerated parent should be terminated** [CONDUCT IS LIKELY TO CONTINUE] if the court finds, based on clear and convincing evidence, that [THE]

(1) **the** period of incarceration that the parent is scheduled to serve during the child's minority is significant considering the child's age and the child's need for an adult's care and supervision; [AND]

(2) there is not another parent willing and able to care for the child; and

(3) the incarcerated parent has failed to make adequate provisions for care of the child during the period of incarceration that will be during the child's minority.

* Sec. 40. AS 47.10.080 is amended by adding new subsections to read:

(p) If the court orders a child committed to the department under (c) of this section for out-of-home placement, the court shall also order that the child's parents and extended family may have visitation with the child at least once a week, beginning within 72 hours after the order is issued, unless the court determines that visitation, even if supervised, may be harmful to the child. When the court grants visitation rights under this subsection, the visitation may be supervised or unsupervised, at the discretion of the department. If the court initially denies weekly visitation rights under this subsection based on a determination that visitation, even if supervised, may be harmful to the child, the court shall order the department to provide for a psychological evaluation or counseling, or both, for the child within 30 days to determine the appropriateness and conditions of visitation that may be consistent with the child's well-being. The department shall report to the court within 30 days after the order under (c) of this section concerning the results of the child's psychological evaluation and counseling, and the court shall determine whether visitation may be granted without harm to the child; the court shall issue appropriate orders to implement the determination.

(q) If the court orders a child committed to the department under (c) of this section for placement in licensed foster care, the court shall order the department to provide the foster parent with a copy of

(1) all initial, updated, and revised case service plans for the child, court orders relating to the child, and the child's medical, mental, and education reports prepared by or for the department, including reports compiled before the child was placed with the foster parent; and

(2) supplements to the plans, orders, and reports described in (1) of this subsection.

(r) If the court orders a child committed to the department under (c) of this section for placement in licensed foster care or for placement with a relative of the child, the court shall order the child's parent, guardian, or custodian to provide the department with

(1) the names, addresses, and telephone numbers of all of the child's medical providers; and

(2) a signed release for each medical provider identified in (1) of this subsection authorizing the provider to disclose the child's medical records to the department.

(s) Notwithstanding AS 47.14.100 and (c)(3) of this section, the department may not, without a court order, change the placement of a child who has been committed to the department under (c) of this section and placed with a relative or a foster home unless

(1) removal of the child is requested by the relative, the foster home, the child, or the child's guardian ad litem or attorney;

(2) a report of suspected child abuse or neglect concerning the relative or foster home is received by the department; or

(3) the child is removed in order to return the child to the parent or guardian or to place the child for adoption and removal under this paragraph is not opposed by the relative, the foster parent, the child, or the child's guardian ad litem or attorney.

(t) The department shall give at least 14 days' written notice by certified mail, return receipt requested, of an intent to request a court order to allow a change in the placement of a child whose change of placement is not governed by (s) of this section. The notice shall be sent to the court, the affected foster parent or relative with whom the child is currently placed, the child, and the child's parent or guardian, guardian ad litem, and attorney. A person to whom notice is sent under this subsection may file an objection to the proposed change of placement if the objection is postmarked or received by the court within 15 days after the person received the notice, and the department's notice must include notification of that right to object. If an objection is filed, the department may not implement the intended change of placement, pending a

court decision on the matter. A person who has filed an objection under this subsection may be represented by an attorney or other representative designated by the person.

* **Sec. 41.** AS 47.10.082 is amended to read:

Sec. 47.10.082. Best interests of child and other considerations. In making its dispositional order under AS 47.10.080(c), the court shall consider

(1) the best interests of the child; and

(2) the ability of the state to take custody and to care for the child to protect the child's best interests under AS 47.10.005 - 47.10.142 [AS 47.10.010 - 47.10.142].

* **Sec. 42.** AS 47.10.083 is amended to read:

Sec. 47.10.083. Review of orders, requests for extensions. In a review under AS 47.10.080(f) and in a hearing related to a request for extended commitment or extended supervision under AS 47.10.080(c)(2) - (4) [AS 47.10.080(c)(1) OR (2)], the court shall, in addition to the requirements of those provisions and the requirements of court rules, determine whether a child continues to be a child in need of aid at the time of the review or hearing. The court may not continue or extend state custody or supervision of the child unless the court finds that the child continues to be a child in need of aid except that, if the child is no longer a child in need of aid, the court may establish a specific timetable for gradual reunification of the family and termination of state custody or supervision if the court makes a finding that immediate reunification would be detrimental to the child.

* **Sec. 43.** AS 47.10.084(a) is amended to read:

(a) When a child is committed under AS 47.10.080(c)(2) or (3) [AS 47.10.080(c)(1)] to the department, released under AS 47.10.080(c)(4) [AS 47.10.080(c)(2)] to the child's parents, guardian, or other suitable person, or committed to the department [OR TO A LEGALLY APPOINTED GUARDIAN OF THE PERSON OF THE CHILD] under AS 47.10.080(c)(5) [AS 47.10.080(c)(3)], a relationship of legal custody exists. This relationship imposes on the department and its authorized agents or the parents, guardian, or other suitable person the responsibility of physical care and control of the child, the determination of where and with whom the child shall live, the right and duty to protect, train, and discipline the child, and the

duty of providing the child with food, shelter, education, and medical care. These obligations are subject to any residual parental rights and responsibilities and rights and responsibilities of a guardian if one has been appointed. When a child is committed to the department and the department places the child with the child's parent, the parent has the responsibility to provide and pay for food, shelter, education, and medical care for the child. When parental rights have been terminated, or there are no living parents and a [NO] guardian has **not** been appointed, the responsibilities of legal custody include those in (b) and (c) of this section. The department or person having legal custody of the child may delegate any of the responsibilities under this section, except authority to consent to marriage, adoption, and military enlistment may not be delegated. For purposes of this chapter, a person in charge of a placement setting is an agent of the department.

* **Sec. 44.** AS 47.10 is amended by adding new sections to read:

Sec. 47.10.086. Reasonable efforts. (a) Except as provided in (b) and (c) of this section, if the court determines that a child is a child in need of aid under AS 47.10.080(c), the court shall, regardless of the subsequent placement of the child, order the department to make reasonable efforts to provide family support services to the child and to the parents or guardian of the child. The department's duty to make reasonable efforts under this subsection includes the duty to

(1) identify available departmental and community services that are designed to sustain and enhance the capacity of a parent or guardian to care for the child at a level of adequacy that will allow the child either to remain in the home or to be returned to the home; the department shall place a high priority on determining whether appropriate community services are available;

(2) actively offer and attempt to provide or to refer the parents to the services identified under (1) of this subsection; the department shall place a high priority on referring the parents to services that are community services;

(3) document the department's actions that are taken under (1) and (2) of this subsection.

(b) The court may determine and order that the department has no duty to make or continue reasonable efforts to provide family support services to a parent or guardian

if

(1) the department provides to the court a verified affidavit that a reasonably diligent search conducted over the time period of at least three months by the department for an unidentified or absent parent has failed to identify and locate the parent;

(2) the parent or guardian is the sole caregiver of the child and the parent or guardian has a mental illness or mental deficiency that, according to a written certification of a psychologist or physician, makes it more probable than not that, even with the provision of family support services for 12 months, the caregiver will be incapable of caring for the child without creating a risk of substantial physical harm to the child;

(3) the parent or guardian has previously been convicted of a crime involving a child in this state or in another jurisdiction and, after the conviction, the child was returned to the custody of the parent or guardian and later removed because of an additional substantiated report of physical or sexual abuse by the parent or guardian;

(4) the parent or guardian has been convicted of murder of a child or manslaughter of a child;

(5) a child has suffered substantial physical harm as the result of abusive or neglectful conduct by the parent or guardian or by a person known by the parent or guardian and the parent or guardian knew or reasonably should have known that the person was abusing the child;

(6) the parental rights of the parent have been terminated with respect to another child because of child abuse or neglect, the parent has not remedied the conditions or conduct that led to the termination of parental rights, and the parent has demonstrated an inability to protect the child from substantial harm or the risk of substantial harm; or

(7) the child has been removed from the child's home on at least two previous occasions, family support services were offered or provided to the parent or guardian at those times, and the parent or guardian has demonstrated an inability to protect the child from substantial harm or the risk of substantial harm.

(c) If the court orders the department to make reasonable efforts to provide family support services, the court shall also order the parent or guardian of the child to make reasonable efforts to participate in the family support services that are offered by the department or referred to the parent or guardian by the department. If a parent or guardian fails to participate or to attempt to participate in the services for 60 days, the department may seek a court order extinguishing the department's responsibility to offer or refer family support services to the parent or guardian. The department must request the court for the new order within 90 day after the date that the parent or guardian failed to participate in family support services and must accompany the request with a petition for the termination of parental rights if the nonparticipating person was a parent and with a new plan for permanent placement of the child. The court shall grant the department's request under this subsection for an order extinguishing the department's responsibility to offer family support services to a parent or guardian if the court finds that it is no longer reasonable to require the department to offer family support services to the parent or guardian; failure of the parent or guardian to participate in family support services offered by the department for 60 days constitutes prima facie evidence that it is no longer reasonable to require the department to offer family support services to the parent or guardian.

(d) If the court determines under (b) or (c) of this section that reasonable efforts under (a) of this section are not required to be provided,

(1) the court shall hold a permanency hearing for the child within 30 days after the determination; and

(2) the department shall make reasonable efforts to place the child in a timely manner in accordance with the permanency plan, and complete whatever steps are necessary to finalize the permanent placement of the child.

(e) The department may develop and implement an alternative permanency plan for the child while the department is also making reasonable efforts to return the child to the child's family under (a) of this section.

(f) In making determinations and reasonable efforts under this section, the primary consideration is the child's best interests.

Sec. 47.10.088. Termination of parental rights and responsibilities. (a)

Except as provided in AS 47.10.080(o), the rights and responsibilities of the parent regarding the child may be terminated for purposes of freeing a child for adoption or other permanent placement if the court finds

(1) by clear and convincing evidence that

(A) the child is a child in need of aid as described in AS 47.10.011; and

(B) the parent

(i) has not remedied the conduct or conditions in the home that place the child at substantial risk of harm; or

(ii) has failed, within a reasonable time, to remedy the conduct or conditions in the home that place the child in substantial risk so that returning the child to the parent would place the child at substantial risk of significant physical harm; and

(2) by preponderance of the evidence that the department has complied with the provisions of AS 47.10.086 concerning reasonable efforts.

(b) In making a determination under (a)(1)(B) of this section, the court may consider any fact relating to the best interests of the child, including

(1) the likelihood of returning the child to the parent within a reasonable time based on the child's age or needs;

(2) the amount of effort by the parent to remedy the conduct or the conditions in the home;

(3) the harm caused to the child;

(4) the likelihood that the harmful conduct will continue; and

(5) the history of conduct by or conditions created by the parent.

(c) In a proceeding under this chapter involving termination of the parental right of a parent, the court shall consider the best interests of the child.

(d) Except as provided in (e) of this section, the department shall petition for termination of a parent's rights to a child, without making further reasonable efforts, when a child is under the jurisdiction of the court under AS 47.10.010 and 47.10.011, and

(1) the child has been in foster care for at least 15 of the most recent

22 months;

(2) the court has determined that the child is abandoned under AS 47.10.013 and the child is younger than six years of age;

(3) the court has made a finding under AS 47.10.086(b) or a determination under AS 47.10.086(c) that the best interests of the child do not require further reasonable efforts by the department;

(4) a parent has made three or more attempts within a 15-month period to remedy the parent's conduct or conditions in the home without lasting change; or

(5) a parent has made no effort to remedy the parent's conduct or the conditions in the home by the time of the permanency hearing under AS 47.10.080(l).

(e) If one or more of the conditions listed in (d) of this section are present, the department shall petition for termination of the parental rights to a child unless the department

(1) has documented a compelling reason for determining that filing the petition would not be in the best interests of the ch. d; a compelling reason under this paragraph may include care by a relative for the child; or

(2) is required to take reasonable efforts under AS 47.10.086 and the department has not provided to the parent, consistent with the time period in the department's case plan, the family support services that the department has determined are necessary for the safe return of the child to the home.

(f) A child is considered to have entered foster care under this chapter on the date of removal of the child from the child's home under this chapter.

(g) This section does not preclude the department from filing a petition to terminate the parental rights and responsibilities to a child for other reasons, or at an earlier time than those specified in (d) of this section, if the department determines that filing a petition is in the best interests of the child.

(h) The court may order the termination of parental rights and responsibilities of one or both parents under AS 47.10.080(c)(5) and commit the child to the custody of the department. The rights of one parent may be terminated without affecting the rights of the other parent.

(i) The department shall concurrently identify, recruit, process, and approve a

qualified person or family for an adoption whenever a petition to terminate a parent's rights to a child is filed. If the court issues an order to terminate under (j) of this section, the department shall report within 30 days on the efforts being made to recruit a permanent placement for the child if a permanent placement was not approved at the time of the trial under (j) of this section. The report must document recruitment efforts made for the child.

(j) No later than six months after the date on which the petition to terminate parental rights is filed, the court before which the petition is pending shall hold a trial on the petition unless the court finds that good cause is shown for a continuance. When determining whether to grant a continuance for good cause, the court shall take into consideration the age of the child and the potential adverse effect that the delay may have on the child. The court shall make written findings when granting a continuance.

(k) The court shall issue an order on the petition to terminate within 90 days after the last day of the trial on the petition to terminate parental rights.

* **Sec. 45.** AS 47.10.092(a) is amended to read:

(a) Notwithstanding AS 47.10.090 and 47.10.093, a parent or legal guardian of a **child** [MINOR] subject to a proceeding under **AS 47.10.005 - 47.10.142** [AS 47.10.010 - 47.10.142] may disclose confidential or privileged information about the **child or the child's family** [MINOR], including information that has been lawfully obtained from agency or court files, to the governor, the lieutenant governor, a legislator, the ombudsman appointed under AS 24.55, the attorney general, and the commissioners of health and social services, administration, or public safety, or an employee of these persons, for review or use in their official capacities. The department **shall** [MAY] disclose additional confidential or privileged information and make **copies of documents** available for inspection [DOCUMENTS] about the **child or the child's family** [MINOR] to these state officials or employees for review or use in their official capacities **upon request of the official or employee and submission of satisfactory evidence that a parent or legal guardian of the child has requested the state official's assistance in the case as part of the official's duties**. A person to whom disclosure is made under this section may not disclose confidential or

privileged information about the **child or the child's family** [MINOR] to a person not authorized to receive it.

* **Sec. 46.** AS 47.10.093(b) is amended to read:

(b) A state or municipal agency or employee **shall** [MAY] disclose**, upon request,** information regarding a case to

(1) a guardian ad litem appointed by the court or to a citizen review board or local review panel for permanency planning authorized by AS 47.14.200 or 47.14.220;

(2) a person or an agency requested to provide consultation or services for a **child** [MINOR] who is subject to the jurisdiction of the court under AS 47.10.010;

(3) **foster parents or relatives with whom the child is placed by the department as may be necessary to enable the foster parents or relatives to provide appropriate care for the child who is the subject of the case, to protect the safety of the child who is the subject of the case, and to protect the safety and property of family members and visitors of the foster parents or relatives;**

(4) school officials as may be necessary to enable the school to provide appropriate counseling and support services to the **child** [MINOR] who is the subject of the case, to protect the safety of the **child** [MINOR] who is the subject of the case, and to protect the safety of school students and staff;

(5) [(4)] a governmental agency as may be necessary to obtain that agency's assistance for the department in its investigation or to obtain physical custody of a child;

(6) [AND (5)] a [STATE OR MUNICIPAL] law enforcement agency **of this state or another jurisdiction** as may be necessary for **the protection of any child** [A SPECIFIC INVESTIGATION BEING CONDUCTED BY THAT AGENCY] or for **actions** [DISCLOSURES] by that agency to protect the public safety;

(7) members of a multidisciplinary child protection team created under AS 47.14.300;

(8) the state medical examiner under AS 12.65;

(9) a person who has made a report of harm as required by

AS 47.17.020 to inform the person that the investigation was completed and of action taken to protect the child who was the subject of the report;

(10) the child support enforcement agency established in AS 25.27.010 as may be necessary to establish and collect child support for a child who is a child in need of aid under this chapter; and

(11) a parent or guardian of a child unless prohibited by a preexisting court order.

* Sec. 47. AS 47.10.141(c) is amended to read:

(c) A child [MINOR] may be taken into emergency protective custody by a peace officer and placed into temporary detention in a juvenile detention home in the local community if there has been an order issued by a court under a finding of probable cause that (1) the child [MINOR] is a runaway in wilful violation of a valid court order issued under AS 47.10.080(c)(2) or (3) [AS 47.10.080(c)(1)], 47.10.142(f), AS 47.12.120(b)(1) or (3), or 47.12.250(d), (2) the child's [MINOR'S] current situation poses a severe and imminent risk to the child's [MINOR'S] life or safety, and (3) no reasonable placement alternative exists within the community. A child [MINOR] detained under this subsection shall be brought before a court on the day the child [MINOR] is detained [,] or, if that is not possible, within 24 hours after the detention for a hearing to determine the most appropriate placement in the best interests of the child [MINOR]. A child [MINOR] taken into emergency protective custody under this subsection may not be detained for more than 24 hours, except as provided under AS 47.12.250. Emergency protective custody may not include placement of a child [MINOR] in a jail or secure facility other than a juvenile detention home, nor may an order for protective custody be enforced against a child [MINOR] who is residing in a licensed program for runaway minors, as defined in AS 47.10.390.

* Sec. 48. AS 47.10.141(f) is amended to read:

(f) If a child [MINOR], without permission, leaves the semi-secure portion of an office, program, shelter, or facility to which the child [MINOR] was taken by a peace officer under (b)(1)(C) [(b)(1)(c)] of this section, the office, program, shelter, or facility shall immediately notify the department and the nearest law enforcement agency of the identity of the child [MINOR] and the child's [MINOR'S] absence. If the same

child [MINOR] is again taken into protective custody under (b) of this section and the peace officer knows that the child [MINOR] has previously been reported under this subsection as missing from a semi-secure placement, the peace officer, in addition to taking the appropriate action under (b) of this section, shall report the circumstances and the identity of the child [MINOR] to the department. Within 48 hours after receiving this report, the department shall determine whether to file a petition alleging that the child [MINOR] is a child in need of aid under AS 47.10.011 [AS 47.10.010(a)(1)]. If the department decides not to file a petition alleging that the child [MINOR] is a child in need of aid, the department shall, within seven state working days after receiving the report from the peace officer under this subsection, send to the child's [MINOR'S] parents or guardian, as applicable, written notice of its determination not to proceed with the petition, including the reasons on which the determination was based. If the department is unable to obtain a reasonably reliable address for a parent or guardian, the department shall keep a copy of the notice on file and, notwithstanding AS 47.10.093, release the notice to the child's [MINOR'S] parent or guardian on request of the parent or guardian. If the department files a petition alleging that the child [MINOR] is a child in need of aid, the court shall proceed under AS 47.10.142(d).

• Sec. 49. AS 47.10.141(g) is amended to read:

(g) If the department files a petition alleging the minor is a child in need of aid under AS 47.10.011 [AS 47.10.010(a)(1)] because the minor is habitually absent from home or refuses available care, the minor's parent or guardian shall attend each hearing held during the child-in-need-of-aid proceedings unless the court excuses the parent or guardian from attendance for good cause. If the minor is found to be a child in need of aid, the court may order that the minor's parent or guardian

(1) personally participate in treatment reasonably available in the parent or guardian's community as specified in a plan set out in the court order; and

(2) comply with other conditions set out in the court order.

• Sec. 50. AS 47.10.142(a) is amended to read:

(a) The Department of Health and Social Services may take emergency custody of a child [MINOR] upon discovering any of the following circumstances:

(1) the **child** [MINOR] has been abandoned **as abandonment is described in AS 47.10.013**;

(2) the **child** [MINOR] has been [GROSSLY] neglected by the **child's** [MINOR'S] parents or guardian, as "neglect" is **described** [DEFINED] in **AS 47.10.014** [AS 47.17.290], and the department determines that immediate removal from the **child's** [MINOR'S] surroundings is necessary to protect the **child's** [MINOR'S] life or provide immediate necessary medical attention;

(3) the **child** [MINOR] has been subjected to **serious physical injury** [CHILD ABUSE OR NEGLECT] by a person responsible for the **child's** [MINOR'S] welfare, [AS "CHILD ABUSE OR NEGLECT" IS DEFINED IN AS 47.17.290.] and the department determines that immediate removal from the **child's** [MINOR'S] surroundings is necessary to protect the **child's** [MINOR'S] life or that immediate medical attention is necessary; or

(4) the **child or a sibling** [MINOR] has been sexually abused under circumstances listed in **AS 47.10.011(7)** [AS 47.10.010(a)(4)].

• **Sec. 51.** AS 47.10.142(c) is amended to read:

(c) When a child is taken into custody under (a) or (b) of this section or when the department is notified of a child's presence in either a program for runaway **children** [MINORS] under AS 47.10.300 - 47.10.390 or a shelter for runaway **children** [MINORS] under AS 47.10.392 - 47.10.399, the department shall immediately, and in no event more than **24** [12] hours later unless prevented by lack of communication facilities, notify the parents or the person or persons having custody of the child. If the department determines that continued custody is necessary to protect the child, the department shall notify the court of the emergency custody by filing, within **24** [12] hours after custody was assumed, a petition alleging that the child is a child in need of aid. If the department releases the child within **24** [12] hours after taking the child into custody and does not file a child in need of aid petition, the department shall, within **24** [12] hours after releasing the child, file with the court a report explaining why the child was taken into custody, **why the child was released, and to whom the child was released**.

• **Sec. 52.** AS 47.10.142(h) is amended to read:

(h) Within 12 [18] months after a minor is committed to the department under this section, the court shall review the placement plan and actual placement of the minor under AS 47.10.080(l).

* Sec. 53. AS 47.10 is amended by adding a new section to read:

Sec. 47.10.960. Liability limitations. Nothing in this title creates a duty or standard of care for services to children and their families being served under AS 47.10. However, subject to the provisions of AS 09.50.250, the department and its officers, agents, employees, or contractors and the state are liable for civil damages as a result of a negligent act or omission in the provision of services to children and their families under AS 47.10.

* Sec. 54. AS 47.10.990(1) is amended to read:

(1) "care" [OR "CARING" UNDER AS 47.10.010(a)(1) AND 47.10.120(a)] means to provide for the physical, [EMOTIONAL,] mental, and social needs of the child;

* Sec. 55. AS 47.10.990(2) is amended to read:

(2) "child in need of aid" means a child [MINOR] found to be within the jurisdiction of the court under AS 47.10.010 and 47.10.011 [AS 47.10.010(a)];

* Sec. 56. AS 47.10.990 is amended by adding new paragraphs to read:

(8) "child" means a person under 18 years of age and a person 19 years of age if that person was under 18 years of age at the time that a proceeding under this chapter was commenced;

(9) "custodian" means a natural person 18 years of age or older to whom a parent or guardian has transferred temporary physical care, custody, and control of the child for the period of time;

(10) "domestic violence" has the meaning given in AS 18.66.990;

(11) "family support services" means the services and activities provided to children and their families, including those provided by the community, a church, or other service organization, both to prevent removal of a child from the parental home and to facilitate the child's safe return to the family; "family support services" may include counseling, substance abuse treatment, mental health services, assistance to address domestic violence, visitation with family members, parenting classes, in-home

services, temporary child care services, and transportation;

(12) "foster care" means care provided by a person or household under a foster home license required under AS 47.35.015;

(13) "guardian" means a natural person who is legally appointed guardian of the child by the court;

(14) "intoxicants" means a substance that intoxicates, including alcohol, controlled substances under AS 11.71, and inhalants;

(15) "parent" means the biological or adoptive parent of the child;

(16) "permanency hearing" means a hearing

(A) designed to reach a decision in the case concerning the permanent placement of a child under AS 47.10; and

(B) at which the final direction of the case involving the child is determined;

(17) "reasonable efforts" means consistent attempts during a reasonable time;

(18) "reasonable time" means a period of time that serves the best interests of the child, taking in account the affected child's age, emotional and developmental needs, and ability to form and maintain lasting attachments;

(19) "serious physical injury" has the meaning given in AS 11.81.900(b);

(20) "sexual abuse" means the conduct described in AS 11.41.410 - 11.41.460; conduct constituting "sexual exploitation" as defined in AS 47.17.290, and conduct prohibited by AS 11.66.100 - 11.66.150;

(21) "support" has the meaning given in AS 11.51.120(b).

* **Sec. 57.** AS 47.12.310(b) is amended to read:

(b) A state or municipal agency or employee **shall** [MAY] disclose **appropriate** information regarding a case to

(1) a guardian ad litem appointed by the court or to a citizen review board or local review panel for permanency planning authorized by AS 47.14.200 - 47.14.220;

(2) a person or an agency requested to provide consultation or services

for a minor who is subject to the jurisdiction of the court under this chapter;

(3) school officials as may be necessary to protect the safety of the minor who is the subject of the case and the safety of school students and staff or to enable the school to provide appropriate counseling and supportive services to meet the needs of a minor about whom information is disclosed;

(4) a governmental agency as may be necessary to obtain that agency's assistance for the department in its investigation or to obtain physical custody of a minor;

(5) a [STATE OR MUNICIPAL] law enforcement agency **of this state or another jurisdiction** as may be necessary for **the protection, rehabilitation, or supervision of any minor** [A SPECIFIC INVESTIGATION BEING CONDUCTED BY THAT AGENCY] or for **actions** [DISCLOSURES] by that agency to protect the public safety; [AND]

(6) a victim as may be necessary to inform the victim about the disposition or resolution of a case involving a minor;

(7) the state medical examiner under AS 12.65;

(8) foster parents and parents of the minor who is the subject of the case; and

(9) health care providers of the minor who is the subject of the case.

* Sec. 58. AS 47.14.240(a) is amended to read:

(a) A local review panel shall review the case plan of each child in the custody of the department who is in a placement other than the child's own home under **AS 47.10.080(c)(2), (3), or (5)** [AS 47.10.080(c)(1) or (3)], 47.10.142, or AS 47.14.100(c) if the case is under the jurisdiction of a court in the judicial district served by the local review panel. A local review panel may request a local review panel in another judicial district to conduct a review and make a report if that local review panel is more convenient for the child and other persons involved.

* Sec. 59. AS 47.14.240(d) is amended to read:

(d) In reviewing a case, the local review panel shall consider the case plan and any progress report of the department or the child's guardian ad litem, court records, and other relevant information about the child and the child's family. The local **review**

panel shall provide to the following persons an opportunity to be interviewed by the local review panel in person or by telephone or to provide written material to the local review panel:

(1) the child whose case is being reviewed if the child is 10 years of age or older;

(2) the parents, custodians, or other relatives of the child;

(3) the child's out-of-home care provider;

(4) the child's guardian;

(5) the child's guardian ad litem;

(6) the case worker or social worker assigned to the case;

(7) **the child's health care providers;**

(8) if the case is governed by 25 U.S.C. 1901 - 1963 (Indian Child Welfare Act),

(A) the child's Indian custodian; and

(B) the designated representative of the child's Indian tribe if the tribe has intervened in the court case; and

(9) [(8)] other persons with a close personal knowledge of the case.

* **Sec. 60.** AS 47.14.240(h) is amended to read:

(h) The report required under (g) of this section must make advisory recommendations based on the best interests of the child in accordance with AS 47.10.082 and must include notification of the right to request court review under AS 47.10.080(f). If the court has scheduled the case for review, the local review panel shall submit its report at least 20 days before the hearing, **and the department shall present to the court the recommendations that are made in the report**.

* **Sec. 61.** AS 47.14.299(4) is amended to read:

(4) "out-of-home care provider" means an agency or person, other than the child's legal parents, with whom a child who is in the custody of the state under **AS 47.10.080(c)(2), (3), or (5)** [AS 47.10.080(c)(1) OR (3)], 47.10.142, or AS 47.14.100(c) is currently placed; in this paragraph, "agency or person" includes a foster parent, a relative other than a parent, a person who has petitioned for adoption of the child, and a residential child care facility;

* **Sec. 62.** AS 47.14 is amended by adding a new section to read:

Article 3A. Multidisciplinary Child Protection Teams.

Sec. 47.14.300. Multidisciplinary child protection teams. (a) Each district attorney shall appoint at least one child protection team whose purpose is to encourage coordination of investigation, rehabilitative intervention, and civil and criminal litigation in child abuse and neglect cases in the district. A team may be coordinated by a team member selected by the team, with the concurrence of the district attorney. At a minimum, a team must include a

(1) peace officer, as defined in AS 11.81.900;

(2) representative from the department;

(3) representative from the district attorney's office;

(4) representative from the attorney general's office;

(5) health care practitioner licensed under AS 08;

(6) mental health professional licensed under AS 08; and

(7) member of a local child advocacy center if the district has a child advocacy center.

(b) A team may invite other persons to serve as team members for particular cases, including educators, school administrators, tribal representatives, guardians ad litem, and personnel from a domestic violence program.

(c) Meetings of a team and participation in a team meeting may occur in person or by teleconference if the confidentiality of team discussions is ensured.

(d) Each team shall develop a written protocol that may be used for investigation of child abuse cases and for interviewing alleged victims of abuse or neglect. The protocol must

(1) be designed to minimize negative effects on children that may be caused by investigations and interviews;

(2) be appropriate for the resources and conditions of the district;

(3) seek to coordinate joint investigations by law enforcement personnel and department staff so that multiple interviews of children can be avoided;

(4) describe the role of videotaping of interviews in child sexual abuse cases; and

(5) provide for referral of children and nonoffender parents to rehabilitative services.

(e) Each team shall develop agreements that are designed to be signed by the agencies represented by the team members specifying the role and responsibility of each agency with respect to team activities. The agreement may include a commitment by one or more agencies to provide office space and administrative services that are necessary for the team's operation.

(f) A team may review child abuse and neglect cases that are reported to law enforcement and department personnel in the team's district. A team may limit its review to complex cases or cases involving substantial harm to a child. A team member may refer cases for review.

(g) A team shall develop policies that provide for an independent review, after completion of related court action, of investigation procedures that were used in cases involving harm to a child. The policies must provide that notice of a review under this subsection will be given to a parent of the child if the parent was not the offender in the case and that public testimony will be allowed during the review. In a subsequent report based on the review, a team may not reveal confidential information about a child or a family.

(h) Except as provided in (g) of this section, proceedings of a team are closed to the public and are not subject to AS 44.62.310 and 44.62.312.

(i) The determinations, conclusions, and recommendations of a team or its members are not admissible in a civil or criminal proceeding. Records or other information collected by a team or a member of the team that is related to duties under this section are confidential and are not subject to

(1) public disclosure under AS 09.25.100 and 09.25.110; or

(2) discovery or subpoena in connection with a civil or criminal proceeding.

(j) Notwithstanding (i) of this section, an employee of the department may testify in a civil or criminal proceeding concerning a case reviewed by a team even though the department's records were reviewed by the team and formed the basis of the employee's testimony and the team's report.

(k) A person who serves on a team is not liable for damages or other relief in an action brought by reason of the performance of or a failure to perform a duty, a function, or an activity of the team.

(l) In this section, "team" means a multidisciplinary child protection team appointed under this section.

* **Sec. 63.** AS 47.14.990(2) is amended to read:

(2) "child in need of aid" means a **child** [MINOR] found to be within the jurisdiction of the court under **AS 47.10.010 and 47.10.011** [AS 47.10.010(a)];

* **Sec. 64.** AS 47.17.020(a) is amended to read:

(a) The following persons who, in the performance of their occupational duties, **or with respect to (9) of this subsection, in the performance of their appointed duties,** have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect shall immediately report the harm to the nearest office of the department:

(1) practitioners of the healing arts;

(2) school teachers and school administrative staff members of public and private schools;

(3) social workers;

(4) peace officers [,] and officers of the Department of Corrections;

(5) administrative officers of institutions;

(6) child care providers;

(7) paid employees of domestic violence and sexual assault programs, and crisis intervention and prevention programs as defined in AS 18.66.990;

(8) paid employees of an organization that provides counseling or treatment to individuals seeking to control their use of drugs or alcohol;

(9) members of a child fatality review team established under AS 12.65.015(e) or 12.65.120 or the multidisciplinary child protection team created under AS 47.14.300.

* **Sec. 65.** AS 47.17.030(d) is amended to read:

(d) Before the department or a local government health or social services agency may seek the termination of parental rights under **AS 47.10**

[AS 47.10.080(c)(3)], it shall offer protective social services and pursue all other reasonable means of protecting the child.

* Sec. 66. AS 47.17 is amended by adding a new section to read:

Sec. 47.17.033. **Investigations.** (a) In investigating child abuse and neglect reports under this chapter, the department may make necessary inquiries about the criminal records of the parents or of the alleged abusive or neglectful person, including inquiries about the existence of a criminal history record involving a serious offense as defined in AS 12.62.900.

(b) For purposes of obtaining access to information needed to conduct the inquiries required by (a) of this section, the department is a criminal justice agency conducting a criminal justice activity.

* Sec. 67. AS 47.17.290(8) is amended to read:

(8) "maltreatment" means an act or omission that results in circumstances in which there is reasonable cause to suspect that a child may be a child in need of aid, as described in **AS 47.10.011** [AS 47.10.010(a)], except that, for purposes of this chapter, the act or omission need not have been committed by the child's parent, custodian, or guardian;

* Sec. 68. AS 47.35.017(b) is amended to read:

(b) An application submitted under this section must contain at least the following information:

(1) the name and address of the applicant [.] and, if the applicant is an agency, corporation, partnership, association, or any other form of organization, the name, address, and title of **each individual** [ALL INDIVIDUALS] who **has** [HAVE] an ownership or management interest in the facility; **if the applicant is an individual, the application must include the name and age of each member of the individual's household;**

(2) the name, physical location, and mailing address of the facility or agency for which the license is sought;

(3) the name and address of the administrator of the facility or agency, if any;

(4) evidence that the administrator or foster parent is an adult with

sufficient experience, training, or education to fulfill the duties of an administrator or foster parent;

(5) a release for the administrator or foster parent and for each other person who is 12 years of age or older, as specified by the department by regulation, who will have contact with individuals served by the facility or agency, authorizing the department to review all federal, state, and municipal criminal justice information, whether of this state, of a municipality of this state, or of another jurisdiction [LAW ENFORCEMENT], medical records, licensing records, and protective services records, identified in regulations adopted under this chapter, that are relevant to the person who is the subject of the release and to the type of license for which the application has been submitted;

(6) two sets of fingerprints, the social security number, and the driver's license number, if any, for each person required to provide a release under (5) of this subsection in order for the department to submit the fingerprints to the Department of Public Safety for the purpose of conducting state and national criminal background checks from criminal justice information received under AS 12.62 and regulations adopted under AS 12.62; the department may not approve an application under this section until the results of the criminal background check have been submitted to the department;

(7) for a facility, the number of individuals that will be served in the facility;

(8) [(7)] the type of facility or agency for which the license is sought;

(9) [(8)] copies of all inspection reports and approvals required by state fire prevention and environmental health and safety authorities for operation of the facility or agency, including any variances granted by these authorities;

(10) [(9)] a plan of operation, as required by the department by regulation;

(11) [(10)] a staffing plan that describes the number of people who will work at the facility or agency, staff qualifications, a description of each person's responsibilities, and, for a facility other than a maternity home, a supervision schedule for the children in care that meets the requirements established by the department by

regulation;

(12) evidence that the applicant is capable of meeting the minimum standards of care established by the department under AS 47.14.120;

(13) [(11)] evidence that the applicant has completed orientation or training required by the department, by regulation, for holders of the type of license for which the application was submitted; and

(14) [(12)] other information required by the department, by regulation, in order to monitor compliance with this chapter and regulations adopted under this chapter.

* **Sec. 69.** AS 47.35 is amended by adding a new section to read:

Sec. 47.35.022. Foster care placement. (a) Except as provided in (b) of this section, the department may not place or continue placement of a child for care for payment under AS 47.10 in a foster home that is licensed under this chapter if the department finds that a person for whom fingerprints are required to be submitted for licensure of the foster home is currently under arrest for, charged with, or has been convicted of, or found not guilty by reason of insanity of, a serious offense.

(b) Notwithstanding (a) of this section, the department may place or continue a placement for foster care if the applicant or licensee demonstrates to the satisfaction of the department that the applicant, licensee, or other person committed the conduct described in (a) of this section at least five years before the placement, and the conduct

(1) did not involve a victim who was under 18 years of age at the time the conduct occurred;

(2) was not a crime of domestic violence as defined in AS 18.66.990; and

(3) was not a violent crime under AS 11.41.100 - 11.41.455 or a law or an ordinance of another jurisdiction having similar elements.

(c) The department shall develop procedures for rechecking criminal justice information records for the information described in (a) of this section for persons who are 12 years of age or older who are living in a licensed foster home with access to children placed by the department.

* **Sec. 70.** AS 47.35.023(b) is repealed and reenacted to read:

(b) Notwithstanding (a) of this section, if an emergency exists and a child must be immediately placed, the department or the department's designee may issue a provisional foster home license on an emergency basis for a period of 90 days or less if the department or the department's designee determines that the applicant meets minimal requirements for emergency conditions and the applicant agrees in writing to provide the fingerprint information described in AS 47.35.017(b) within 30 days of the placement of a child in the foster home. The department may not issue a license under this subsection before checking state and national criminal justice information available to the department under AS 12.62 and regulations adopted under AS 12.62 about the administrator or foster parent and each person who is 12 years of age or older in the foster home who will have contact with the child. If the department cannot obtain direct access to the state and federal criminal justice information, the department shall request the agency having primary law enforcement responsibility for the geographic area in which the prospective foster home is located to obtain the information and provide it to the department before the license is issued under this section. If the criminal justice information readily available to the department shows an offense which a person would be required to notify the department under AS 47.35.047(b), the department may not issue the license under this subsection. If the additional criminal justice information available from the fingerprint search or another source after the license is issued reveals that the person has a record for one or more of these offenses, the department shall immediately revoke the license and move the child to an appropriate placement. For purposes of obtaining criminal justice information under this subsection, the department is a criminal justice agency conducting a criminal justice activity under AS 12.62.

* **Sec. 71.** AS 47.35.047(b) is amended to read:

(b) A licensee shall notify the department within 24 hours after having knowledge of a conviction or indictment, presentment, or charging by information or complaint of an administrator, foster parent, member of the licensee's household, regular volunteer, or staff person for a **violation of the following laws or the laws of another jurisdiction with similar elements:**

(1) offenses against the family and vulnerable adults under

AS 11.51;

(2) perjury under AS 11.56.200;

(3) offenses included in the definition of "serious offense" under AS 12.62.900 [FELONY, FOR A MISDEMEANOR CRIME OF ASSAULT, RECKLESS ENDANGERMENT, CONTRIBUTING TO THE DELINQUENCY OF A MINOR, OR MISCONDUCT INVOLVING A CONTROLLED SUBSTANCE, FOR THE CRIME OF PERJURY, AS DEFINED IN AS 11 OR THE LAWS OF ANOTHER JURISDICTION, OR FOR A SEX CRIME AS DEFINED IN AS 12.62.035].

* Sec. 72. AS 47.35.900 is amended by adding new paragraphs to read:

(20) "criminal justice information" has the meaning given in AS 12.62.900;

(21) "domestic violence" has the meaning given in AS 18.66.990;

(22) "serious offense" has the meaning given in AS 12.62.900.

* Sec. 73. AS 47.10.080(k), and 47.10.990(7) are repealed.

* Sec. 74. COURT RULE CHANGE; EXPEDITED APPEALS. (a) AS 47.10.080(i), as amended in sec. 37 of this Act, has the effect of amending Rule 218, Alaska Rules of Appellate Procedure, by requiring that expedited appeals from a judgment or an order under AS 47.10 be decided within a fixed timeframe.

(b) Section 37 of this Act takes effect only if this section receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

* Sec. 75. COURT RULE CHANGES; CINA RULES. (a) Many provisions enacted or amended by secs. 26 - 56 and 58 - 60 of this Act have the effect of amending the Alaska Child in Need of Aid Rules, including rules regarding notice, parties, hearings, filing of petitions or reports, court review of orders, termination of parental rights, and duties of the Department of Health and Social Services.

(b) Sections 26 - 56 and 58 - 60 of this Act take effect only if this section receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

* Sec. 76. APPLICABILITY. This Act applies to all new cases or proceedings filed with the court on or after the effective date of this Act and to motions filed with the court on or after the effective date of this Act in cases or proceedings pending before a court on the day

before the effective date of this Act.

* Sec. 77. REVISOR'S INSTRUCTION. The revisor of statutes shall replace the term "minor" with the term "child," in the following statutes:_____

_____.

* Sec. 78. This Act takes effect immediately under AS 01.10.070(c).

Jennifer S. H. Taylor
P. O. Box 424,
Craig, Alaska 99921
907 - 826 3066

Thursday Afternoon, House Bill 375 HESS Committee Hearing, April 2nd, 1998

Con Bunde, Chairman, Health Education and Social Services Committee.
Room 104, fax:465-3871; ph: 800 892-4843

Constituent Testimony concerning House Bill 375, in the Legislature of the State of Alaska, Twentieth Legislature, Second Session. I submit my opinion and testimony to the House Committee of Health, Education, and Social Services, respectfully requesting its distribution to each Committee member, as follows:

It is my limited understanding that the opinion of the general public reflects fear of the loss of the liberty of privacy and control for parents, and the unwarranted intrusion by government entities also figures prominently in over-all resistance to H.B. 375. Nonbeless, there are portions of this bill I believe most worthy of redemption and which merit close examination, in particular consideration of the timely need for protection of the welfare of Alaska's children and Alaska's future.

Addressing Section 11. and Section 12. of HB 375 I find it imperative to point out that long term abandonment and lack of support of children left in the presumptive care of another, unemployed parent, where child support arrearages exceed the past due obligation of one year, or $5000. as according to the Federal Child Support Recovery Act of 1992 (Title 18, Chapter 11A, Section 228) are commutative in the new equation for desperate poverty for many Alaskan children.

It is appropriate that this bill in particular address the issue of nonsupport of children as criminal, because the blatant neglect of children by parents who accumulate arrearages representing debts to their children of many months without support, reflects extreme indifference to the children's well-being and survival.

Following this Committee's attentive dedication, working in tedious Hearings until 11:00 p.m. last night on school funding, there is no doubt of your commitment to Alaskan children. It is a dedication which should be recognised by every one of our children, but which unfortunately cannot be realized by all our youth when so many are growing up with the confirmed belief that their government, as well as at least one of their parents, threw them away.

Opposition to the welfare of Alaskan children comes in the guise of displaced anger from parents who have abandoned, or are otherwise separated from their children. Significant opposition to the daily needs of innocent and defenseless children, too young by law to support themselves, is heard by you time and again

from parents who never formed adequate parental bonds with their children and lacked incentive to ensure familial ties. More often than not, the absent parents who abandoned their children have moved onto second families and their priorities are dominated by new spouses who resent the economic and emotional competition of spouses' prior relationships.

The parent left with sole physical custody in Alaska by "default", has the very tangible burden of shouldering double the responsibility of that of a parent in a unified family. Child Support Civil Rule 90.3 Commentary section VI B) freely acknowledges the, "percentage of income approach used in Alaska tends to slightly understate support relative to the national average for cases in which the custodial parent has child care expenses."

HB 375 page 10 speaks to the state's interpretation of the severity of nonsupport being charged as a class C felony, when the arrearages reach $10,000. My concern is that there is currently so much bad press given to CSED from the obligors in not allowing for fair modifications, and that there are in fact, so many AK CSED cases currently which have gone without consequence, to exceed the $10,000 ceiling, that sufficient pressure will eventually result in the elimination of this section unless "lawful excuse" exceptions and clearer conditions of culpability are delineated in Sec. 11.51.115.

Alaska Civil Rule 90.3 gives a list of exceptions allowing for court interpretation of good causes for support modifications such as unusual circumstances. In my mind $10,000. in child support arrearages represents an AK average of 20 months of no financial support to a child not on welfare, and waiting this long sends a definitive message to our children of our dire lack of concern for their survival. Current AK law, AS 11.51.120(a) Criminal Nonsupport as a Misdemeanor A is rarely upheld for prosecution even when obligors are on state probation or parole and as such are prohibited from committing misdemeanor crimes as a condition of their release. (I can provide supporting documentation.)

This week marked one hundred years since Russian America was sold for American rule of Alaska. Alekandre Baranov knew in the 1790's that civil relations amongst his growing colony depended upon enforcing the responsibility of the Russian fathers toward their half-Native children while in the custody of their Native mothers. Were Alaskan children sold-out with Russian America?

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Child support arrearages have been accumulating all over Alaska in direct inverse proportion to the custodial parent's moral and the childrens' diminishing standard of living. As the nurturing parent's resources rapidly dwindle, the real problem is not to absolve the noncustodial parent's arrearages, but how do we feed, provide and heat homes, buy warm clothing, and give nurturing care to the

children?

Government officials wonder of our state-wide predicament when Welfare support is phased out. I can answer some of these questions considering I have raised three children entirely alone since their conception, for over thirteen years, without any welfare assistance, and rarely with child support from their well-heeled fathers.

I am confident you could not imagine the physical and emotional stress I have endured. Still, their fathers will not take these children, even for a visit. One father has lived three doors away for the past four years and gone out of his way to avoid all contact with his sons for this duration. As a certified teacher I cannot find work in this part of Alaska, though I am hopeful to "relocate" to a job and home for the children; I have been on the state register as a Child Support Enforcement Officer I for two years, Alaska resident for 20 years. Construction work has kept me away from my children for 15 hours at a time, six days a week, and the cost of child care is prohibitive. You may laugh and flippantly say the children won't starve without child support. I challenge you to do the math. I do all our own carpentry, electrical repairs, plumbing, truck repairs and maintenance, and when I do, a youngster misses a meal, or two. We missed having a toilet in our home, in town, for three weeks last year when the floor fell through. Sometimes the children dress for school on a floor of ice, and they cry. There hasn't been a kitchen faucet to use in almost a year since the counter fell in, and the floor won't support a real fridge. The funny part is that one of the absent parents owns four apartments and various real estate out of state for rental income, living most of the year in a luxurious home in Homer. The other absent father owns five trucks, two full size mobile homes, and a large, expensive substance abuse addiction. Their combined total for child support arrearages exceeds $50,000. Our annual family income for the past three years has been our permanent fund checks. We try to live on less than half the means of federal "below poverty" standards.

Do not dismiss me as a single case who fell through the cracks. I had my college degree and 24 graduate credits prior to the birth of my first child. I have put my parental responsibilities above all, because of my childrens' absolute need. Every Alaskan family is vulnerable to being reduced to the status of a single parent. Extreme poverty of rural Alaskan children of single parent households, not only elevates their susceptibility to abuse from stressed-out parents, poverty is the most documented reason for poor performance in school, and the lack of adequate nutrition and proper growth.

A perverse and pervasive trend has young, financially distraut single mothers seeking security with boyfreinds who are impatient and indifferent to the children and subject the children to abusive torment, and sometimes murder.

A weight is upon you to facilitate Alaskan childrens' most productive entrance into a friendly society, by ensuring the collection of the child support owed to them by their own parents. The support is their reassurance their government is working for them to keep them alive, healthy and secure. It is the most important message many Alaskan children will ever receive from Alaska. Supporting our children is the only way you can ensure that they, in turn, will support you in your twilight years in Alaska.

Please note - - - denotes the end of the section planned for the three minute limit during teleconference this afternoon.

Thankyou for the opportunity to voice my opinion and have it heard by the Alaskan House of Representatives HESS Committee.

Respectfully,

Jennifer S. H. Taylor

DATE: April 2, 1998
TO: The House Health, Education and Social Service Committee 3 P.M. Discussion
C/O: Representative Con Bunde

TESTIMONY FOR HB 375 GIVEN BY Bernadine Janzen 376-0366
Fax. (907)376-0366

My name is Bernadine Janzen and my husband, myself and our two adopted children live in Wasilla. I address you today as a person who lives " In the Trenches" with two siblings who were severely neglected and abused. Our children where adopted from Washington State after we moved to Alaska. They have been with us now 5 years. At the time of adoption they were 7 and 9 ½ years old. Today the children are 13 and almost 14 ½ years old. While we were given parts of their tragic story there were areas of their life that had been lost or unread by overburden social workers. We searched for answers of : "Why", "How" and "What" would cause our children to act without remorse or conscious. Three years ago, through much searching and requesting of files, we discovered more of their past. While we knew of the neglect and abuse we did not know the depth it had gone ..... We grieve for our children's lost childhood's.

At ages 1 and 2 ½ our children were saved by State intervention. For the next 3 years my children spent time moving back and forth to biological mom's home only to be removed again and again due to her inability to stay clean. Each time our children were replaced in yet another, different foster home. Each time their belongs were placed in their luggage of black trash bags. After all the physical and sexual abuse, my children suffered more abuse from a State, who meaning well, moved them again and again. At ages 4 and 5 ½ years old mom's rights were terminated and our children moved from one unsuccessful placement to another with the State now attempting to find permanency for their young lives. Even at this young age, they were, "very hard to wear" children. The foster placements which had intended to adopt our children changed their minds after 6-8 months due to the children's disruptive behaviors.

We almost did not adopt these two children after living with them for a year. Our reality was they were going to be difficult to rear. Their reality was more foster homes after us. If a high school principal and a B.S. in Correctional Recreation could not do this who could. We believed that with love and consistency we could help them have a better life. We found this not to be enough. They need so much more for their wounded hearts.

My husband and I understand more of the "Why" they are the way they are. Now we need to learn "How" and "What" we can do to help our children understand:

a) We will not allow you to self mutilate
b) Fire is not a way to express you anger
c) Destroying property is an unacceptable way to express frustration
d) It is not kind to beat up on younger and weaker beings just because you can

Please consider four areas as you continue your work. 1) Mental Health Issues of neglected and abused children 2) Monitoring abused and neglected children as they age 3) How many moves is to many? 4) Assault or Battery Convictions

Nation wide we have 50% disruption rate in older "special needs" children. For Governor Knowles to achieve the "strong family" in Alaska this committee must be sensitive to children of extreme abuse and neglect and the mental health issues which they bring with them. While I have read the information I find only several brief references to mental health. Families adopting the Seriously/Severely Emotionally Disturb child must be trained to help change "thinking errors" these children may have about care givers. Assigning a therapist will not be enough.

While DFYS has been sensitive to our needs as a family they have had policies and laws that have prohibited them from supporting the needs of S/SED children who were neglected and abused children. Many of these children were pre-verbal when abuse was inflected on them. They have triggers that run so deep know one could be expected to know what to look for. Our society reels from youth violence. Currently schools are a prime target for children who are expressing their rage. Logical consequences become abusive, innocent "jarrings" in the hallway trigger a "fight or flight response" or rejections from a girl set off abandonment issues. Many young are expressing rage with guns. We would like you to consider, as part of prevention, monitoring abused and neglected children as they age. They do what was done to them. They will neglect and abuse their own children. To truly protect the future generation the neglected and abused child of today will need close supervision.

We hope the team will also be very sensitive to, How many moves is to many? We know that to have homes that are ready and willing to take children in a moments notice is to say the least, impossible. We have pro and con feelings about orphanages. Our children only suffered 10 different moves. What is a "timely manner" for placement? Please, let's not be a State that adds to the child's mental health issue of "attachment" by "home hopping" them. Please be pro-active in this area.

It is my understanding that you will be looking at Sex Offenders, Domestic Violence Offenders and Alcohol/Drug Offenders as being restricted from the lives of our children. We would also, ask you to include in this category those who have Assault and Battery Convictions. While a wife or girlfriend might not file a report on her husband or boyfriend someone in the community may. We need to look at all acts of violence and unhealthy living as potential abusers of our children.

A child's cries of, "IT'S NOT FAIR!" . . . cannot express loud enough what was done to our children and what we know is probably happening to another child this moment, somewhere in Alaska.

We applaud your very hard work. We support HB 375. Please contact us if there is anything we can answer or with anything we can be of help. Thank you for your time.

CSHB 375 "F"	CSHB 375 "B"	HB 375 A"	Subject	Statutes
1	1	1	Intent & Policy	
2	2	2		10.06.961(a)
3	3	3	Murder One	11.41.100(a)
4	4	4	Murder Two	11 41.110(a)
5	5	6	Kidnapping	AS11.41.300(a)
6	6	7	Kidnapping	11.41.300(d)
7	7	8	Indecent Exposure One	11.41.458
8	8	9	Indecent Exposure Two	AS11.41.460
9	9	10	Endangering Welfare One	AS11.51.100
10	10	11	Endangering Welfare Two	11.51.110
11	11	12	Criminal non-support	AS11.51.120(a)
12	12	12		11.51.120(c)
13	13	none		12.55.025(i)
14	14	13		AS12.55.125(c)
15	15	14	Penalties for Crimes	12.55.125(k)
16	none	none		AS12.55.155(e)
17	16	17	Death Reporting	AS12.65.005(a)
18	17	18	Fatality Team	AS12.65.015
19	18	19	Records/Duties/ Confidentiality (Immunity)	AS12.65.000
20	19	20	Teachers Certificates Revoked	AS14.20.020(f)
21	20	21		AS14.20.030(b)
22	21	23	Functions/Powers District Judges/Magistrate	AS22.15.100
23	23	none	Termination	25.23.180(c)
24	24	1	Findings	47.05.065
25	25	25	Adoption Compact	47.05.090
26	26	26	Construction	AS47.10.005
27	27	27	Jurisdiction	47.10.010
28	28	28	Children in Need of Aid	AS47.10.011
29	29	29		AS47.10.020
30	30	30		AS47.10.020(b)
31	none	none	Proceeding Notice	AS47.10.030(b)
32	31	31		AS47.10.050(a)
33	32	none	Foster Parents\ Others Testify	AS47.10.070(a)
34	33	33	Adjudication Hearing 120 days after probable cause	AS47.10.080(a)
35	34	34	Commitment	47.10.080(c)
36	36	35		47.10.080(f)
37	37	36	Appeal CINA	47.10.080(i)
38	38	37	Permanency Hearing	47.10.080(l)
39	39	38	CINA if Incarcerated	47.10.080(o)
40	40	none	Visitation	47.10.080

CSHB 375 "F"	CSHB 375 "B"	HB 375 A"	Subject	Statutes
41	41	39	Best Interests of the Child	47.10.082
42	44	40	Reasonable Effforts /Termination	AS47.10
43	45	41	Confidential \ Privileged Information	AS47.10.092(a)
44	46	42	Information Disclosure	AS47.10.093(b)
45	48	43		AS47.10.141(f)
46	49	none	Habitually Absent	AS47.10.141(g)
47	49	45	Emergency Custody	AS47.10.142(a)
48	51	46	Custody of Child Runaway	AS47.10.142(c)
49	52	none	Plan Review	AS47.10.142(h)
50	53	53	Duty of Care	AS47.10.960
51	54	47	Definition- Care	AS47.10.990(1)
52	55	none	Definition-CINA	47.10.990(2)
53	56	48	Definitions	47.10.990
54	57	49	Information Disclosure	47.12.310(b)
55	none	none	Foster Home Arrangements	47.14.100(a)
56	none	none	Foster Care-DFYS	47.14.100(d)
57	34 (#2)	none	Foster Care-Relatives	47.14.100(e)
58	34 (#1)	none	Out of Home Care	47.14.100
59	59	none	Review Panel-Review	47.14.240(d)
60	60	none	Review Panel-Court	47.14.240(h)
61	62	52	Multidisciplinary Child Protection Team	AS47.14.300
62	63	54	Definition-CINA	AS47.14.990(2)
63	63	55	Report of Harm	AS47.17.020(a)
64	none	none	Reporting Requirements	AS47.17.020
65	65	none		AS47.17.030(d)
66	none	none	Protective Injuctions	AS47.17.030
67	65	56	Investigation	47.17.033
68	none	none	DV Appropriate Steps	17.17.035(b)
69	67	57	Maltreatment	AS47.17.290-8
70	68	58	Application Requirements	AS47.35.017(b)
71	69	59	Foster Care Placement	AS47.35.022
72	70	60	Placement \ Emergency	AS47.35.023(b)
73	71	61	Notification	AS47.35.047(b)
74	72	62	Definitions	47.35.900
75	73	63	Repealed Statutes	AS47.10.080(k)/990(7)
76-80	74-78	64-80	Court Rule Amendments Effective Date	

Petersburg Mental Health Services, Inc.
Post Office Box 556 Petersburg, AK 99833 (907) 772-3332

To: Con Bunde

From: Susan Ohmer, LCSW
Director

Re: House Bill 375
Crimes Against Children

Date: April 2, 1998

It has come to my attention that changes are being made which prevent DFYS social workers from working with a family and protecting children who witness domestic violence. The implication is that DFYS intervention is unnecessary if the child is "only witnessing" abuse rather than feeling herself or himself the back of a hand.

In my experience as director of PMHS, let me state emphatically that the idea that a child's well-being and even SAFETY is not in danger when living in a violent home is incorrect. Every day our agency treats children who are experiencing the sequelea of abuse and of witnessing the abuse of others. Every day we see the impact of what violence and abuse in the home does to children.

Alaska has the highest rate of domestic violence in the nation. Child abuse is 15 times more likely to occur in families where domestic violence is present. Therefore, it can be said that living in such a home automatically puts them at significant risk for abuse as well. Why tie the hands of DFYS social workers to intervene?

Alaskan children have nearly the highest rate of victimization in the nation. Children who witness violence have a variety of responses: behavioral difficulties, emotional difficulties, post-traumatic stress symptoms, attachment difficulties, and learning well that VIOLENCE DOES WORK to get what you want.

As a professional working in the field of trauma, I am alarmed what the changes proposed in this bill would cause for my child clients.

Dale Stone
Chief of Police
Phone (907) 772-3838

PETERSBURG
POLICE DEPARTMENT

P.O. Box 329, Petersburg, Alaska 99833

Bruce Westre
Captain
FAX (907) 772-3504

2 April 1998

Rep. Con Bunde
Chair - House Committee on Health, Education, and Social Services

Representative Bunde:

It has been brought to my attention that House Bill 375, Child Protection, has been modified by deletion of certain language. This deleted language authorized DFYS to act in cases where children, although not the direct victims of personal violence, nonetheless are repeatedly exposed to acts of domestic violence.

I fear deletion of this language implies that children are not legitimate victims because they do not suffer direct harm from repeated exposure to acts of domestic violence. Of course we all know that such an implication would not be based on fact. Volumes of research conclude that children are severely effected by being exposed to violence within the family unit. The truth is, domestic violence is a crippling social cancer that is perpetuated through the learned behavior of individuals growing up in an atmosphere of violence. These individuals often become involved in other crimes in addition to domestic violence. As a police officer, I continually observe this reality. Unless the pattern of learned violence can be broken, police are forced to deal with the effects of domestic violence for generations.

Although time does not allow me to adequately express my strong feelings on this issue, I earnestly request you not modify this bill, in any way, that limits the authority of DFYS to act as necessary in these situations. Provide DFYS with the tools they need to be proactive in dealing with the obscenity of children being conditioned to think that violence is "normal" behavior.

Thank You,

Dale Stone
Chief of Police

cc: DFYS

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PETERSBURG, ALASKA 99833

FACSIMILE TRANSMITTAL SHEET

TO	FROM
REP. CON BUNDY, CHAIR	Cathy Boyington, S.S.A. II
HOUSE COMMITTEE ON HEALTH	
EDUCATION AND SOCIAL SERVICES	Central Council, Petersburg
COMPANY	DATE / TIME
	April 2, 1998
FAX NUMBER 465-3871	TOTAL NO. OF PAGES INCLUDING COVER: 2
	PHONE NUMBER / SENDER'S PHONE NUMBER
	(907) 772-4088
RE:	FAX NUMBER
MODIFICATION: HOUSE BILL 375	(907) 772-3637

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

REPRESENTATIVE CON BUNDY,
IT HAS COME TO MY ATTENTION THAT MODIFICATIONS HAVE BEEN PROPOSED THAT AMEND HOUSE BILL 375, ESSENTIALLY DELETING LANGUAGE THAT WOULD GIVE STATE DIVISION OF YOUTH AND FAMILY SERVICES SOCIAL WORKERS THE POWER TO INTERVENE IN CHILDRENS LIVES WHERE DOMESTIC VIOLENCE IS AN ISSUE. IT IS ESSENTIAL THAT THIS ISSUE REMAIN IN THE LANGUAGE OF THE BILL.
DOMESTIC VIOLENCE DIRECTLY IMPACTS THE LIVES OF CHILDREN RESIDING IN HOMES WHERE THIS IS AN ISSUE. THIS IS AN OPPORTUNITY FOR OUR STATE TO DIRECTLY IMPACT THE LIVES OF THESE CHILDREN. IMPACT STUDIES SUPPORT THIS STATEMENT: WE KNOW THAT THERE ARE BOTH SHORT AND LONG TERM MENTAL/EMOTIONAL.

CONSEQUENCES FOR THESE SILENT VICTIMS OF DOMESTIC VIOLENCE.

PLEASE DO NOT ALLOW THIS BILL TO BE AMENDED!!!

THIS IS AN OPPORTUNITY FOR OUR STATE TO BE PROACTIVE IN OUR APPROACH TO WORKING WITH THE VIOLENCE THAT TOUCHES CHILDRENS LIVES EVERY DAY.

Alaska State Legislature

Please enter into the record my testimony to the [illegible]
committee name

committee on HB 375 dated [illegible]
bill/subject

HB [illegible] based on the Federal Child [illegible] and [illegible] Act of 1998 [illegible] is [illegible] the extreme uses of this act. [illegible] HB 375 [illegible].

HB 375 is a combination of FCS [illegible] Childrens Bill of Rights [illegible] not ratified by US Senate

Signed: [illegible signature]
Testifier

Childrens Rights Council
Representing (Optional)

317 Maple Kodiak 996[illegible]
Address

486-2290
Phone No.

Homeowner Facing Trial in Child Endangerment Case

By Judith Schumann Weizner

Jim Fawcette, a 42 year-old married father of two, faces the possibility of a 30 year jail sentence if he is found guilty in next week's trial on charges of child endangerment as well as on several lesser violations. Federal prosecutors say the charges against Mr. Fawcette stem from his attempt to avoid complying with two provisions of the Federal Child Safety and Education Act of 1998 (FCSEA).

[illegible]

JIM FAWCETTE

[illegible]

Alaska State Legislature

Please enter into the record my testimony to the HESS Committee
committee name

committee on HB 375 , dated April 2, 1998 .
bill/subject

Dear Committee Members:

Please allow a reading of this revised bill one more time. Having a 15yr old in crisis and in need of protection from emotional abuse. PL 105-89 needs to be passed in its entire portions, not bits & pieces. As a child advocate for over 6 yrs I am heartbroken that this is not being considered. Foster parents like Mrs Graham are experiencing these problems daily. Terminating parental rights are not being emphasized clearly, as well as, protecting parental rights when ~~lost~~ false charges are laid. Our children need their rights protected by the law and not by adding to DFYS power to pick & choose who is protected and who is not. Thank you

Signed: Marc Schmelt
Testifier

Parents United for Custodial Justice & Hear My Voice
Representing (Optional)

2010 Wasilla Fishhook Rd, Wasilla AK 99654
Address

907-357-3618
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name

committee on HB # 375 . dated April 2ND, '98.
bill/subject

What is the language to make the "order from Court", & get the administrative agency; according to your admendments?
I have a question on sec # 11 & sec # 12 on page 8.

When referring to the original draft sec(b) was included; but sec(b) was not included in the 2ND & 3rd draft. So is sec (b) of Sec 11.51.120 of the original Statutes deleted or not? Or does sec(b) remain as in the original statute Sec 11.51.120?

Can you clarify what you intend to do with sec(b) of this particular statute? I have researched the original and am now confused.

Personally I do not agree with "criminalizing non-payment of child support," concept. There are too many astounding circumstances surrounding child support.

my concern is with AS 11.51.115 & AS 11.51.120.

Signed: Carol Palmer
Testifier

"Parents United for Custodial Justice"
Representing (Optional)

PO Box 2402, Palmer, Alaska 99645
Address

(907) 746-2863
Phone No.

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House H&SS
Committee Name

Committee on HB 375 Dated 4/2/98
Bill / Subject

I am chairman of the PANDA (Prevent Abuse and Neglect through Dental Awareness coalition) and have been working on the subject of this bill for 3-4 yrs. I'm concerned that this bill is coming into the picture to late. Brain Developme begins pre-natally and has explosive development after birth. I'm Sending information in tonight's packet that supports this. This bill addresses this new material but falls back on the old model - You are just adding to a broken model. You have an opportu to make a difference, listen to what the experts in the field are saying ie Dr Perry, Dr Kohl Dr Newman, Maurice Merleau-Ponty (Primacy of Perception) - I am sending a chapter from this book written in (1941?)

I'm also Sending information on a need for a new medical model - this needs to be Considered as you develop this bill - change needs to be made in prevention of the problem (ie parent training) also changes need to be made in handling the problem children later when they are in trouble and causing problems in society

SIGNED: _____
Testifier

PANDA (Prevent Abuse and Neglect through Dental Awareness
Representing

1329 Mc Grath Rd Fbks Ak 99712-1277
Address / Phone Number

P.A.N.D.A. is an acronym that stands for Prevent Abuse and Neglect through Dental Awareness

P.A.N.D.A.

The Alaska P.A.N.D.A. Coalition; 3305 Arctic Boulevard, Suite 102; Anchorage, AK 99503

Alaska Academy of General Dentistry
Alaska Area Native Health Service
Alaska Chapter International College of Dentists
Alaska Dental Society
Alaska Society of Dentistry for Children
Alaska State Dental Hygienists' Association
Alaska Women's Aid in Crisis
Anchorage Dental Assistants Society
Delta Dental Insurance Company
Multiple Risk Managers, Inc.
UAA Dental Programs
USAF, 3rd Medical Group, Elmendorf AFB AK
State of Alaska, Division of Family and Youth Services
State of Alaska, Division of Public Health,
Sections of Maternal, Child, and Family Health and
Public Health Nursing, Medicaid Services

Maurice Merleau-Ponty

The Primacy of Perception

and Other Essays

Edited by James M. Edie

Northwestern University

in Phenomenology

and Existential Philosophy

Maurice Merleau-Ponty

IN PRAISE OF PHILOSOPHY

translated by John Wild and James M. Edie

William Earle, James M. Edie, and John Wild

CHRISTIANITY AND EXISTENTIALISM

Maurice Merleau-Ponty

THE PRIMACY OF PERCEPTION

edited by James M. Edie

Maurice Merleau-Ponty

SIGNS

translated by Richard C. McCleary

Henry Duméry

THE PROBLEM OF GOD IN PHILOSOPHY OF RELIGION

translated by Charles Courtney

Maurice Merleau-Ponty

SENSE AND NON-SENSE

translated by Hubert L. Dreyfus and Patricia Allen Dreyfus

4 / The Child's Relations with Others[1]

Translated by William Cobb

Introduction

By way of introduction I should like to indicate to you, in this lecture and the next, what place this year's subject occupies within the study of child psychology in general.

1. "Les relations avec autrui chez l'enfant," from the series *Cours de Sorbonne* (Paris, 1960).

The subject of child psychology is of more than casual interest in any philosophical attempt at understanding individual and intersubjective existence. Freud showed that childhood is important, and in some respects decisive, for the character of adult life that follows it. This raises a serious question of principle for any account wishing both to describe the specific motivations and general nature of adult life and to acknowledge the continuity of that life with childhood. Granted that the child's early development has a profound influence on adult life, how, in principle, is that influence possible?

If, as has often been done, we begin with a naturalistic view of the child, in which the acquisition of such things as reflectivity, an ideal image of oneself, values, responsibility, etc., is explained in terms of a process essentially causal in nature, then consistency and continuity demand that we maintain this naturalism in accounting for the phenomena of adult life as well. The demonstrated failure of such theories to account for the phenomena of adult existence in turn forces us to abandon naturalism and mechanism in child psychology—unless we want to hold that to grow to maturity is to pass from one ontological order to another.

If, on the other hand, the child's growth is explained in terms of a cognitive grasp of the world that is held to be the condition for any concrete involvement in the world—if immediacy is denied the child merely in order to make theoretically plausible his passage to reflectivity—such a view overlooks important facts of adult as well as child existence. Psychologists have often spoken of learning in the child as though relations with self, world, and others originate in contemplative knowledge. Yet ordinary experience shows that, in imitating others, in learning to walk, in becoming familiar with an environment, what occurs cannot be explained by the notion that there is first an intellectual act of "knowing" rules, maps, or words and then a move to use them. Intellectualism of this kind is, therefore, an unsatisfactory alternative to naturalism in explaining the nature of childhood existence as well as its influence on adult life.

Merleau-Ponty has elsewhere criticized these two modes of explanation in attempting a description of adult existence. In "The Child's Relations with Others" his task is less critical than descriptive, less occupied with the refutation of theories which would reduce existence to either Nature or Thought than with finding terms for a positive description of the origin of intersubjective relations. Throughout the essay he endeavors to describe these relations in a language that avoids either of the reductions mentioned above.

The essay itself is a fragment of a larger lecture course in child psychology. Its rather abrupt ending suggests that the inquiry was extended in further lectures. No other texts on the subject by Merleau-Ponty are available, however, and for reasons indicated above it was decided to publish this essay in English as it stands.

I am grateful to Michèle Jacquemain and Robert V. Stone for checking the translation and making many improvements.—*Trans.*

You can easily see the relation between this year's proposed subject and the subject we dealt with last year. Last year we attempted a study of certain aspects of the child's relations with nature—for example, the child's perception. These included the child's knowledge of external natural facts, also his representation of external facts (e.g., in drawing), the way his imagination makes use of perceptual experiences, his organization of these experiences into causal relations, and, finally, what has sometimes been called the child's conception of the world—that is, the group of ideas (if such they can be called) that would permit the child to have a view of the world.

The last paragraph brings us to the question of intelligence in the child, and you can see that, regardless of the diversity of questions we raised last year, they all involved not the relation between the child and other living beings but rather the child's relations to nature.

This year, on the contrary, in discussing the child's relations with others, we will be concerned with his relations with his parents, his brothers and sisters, other children, and even, if there is time, with his school environment, his social class, and, in general, his relation to culture, to the civilization to which he belongs. It is quite likely that we will not be able to treat these last questions this year, since to do so would take us too far and we have enough to occupy ourselves in the child's relations to parents, brothers and sisters, and other humans.

It might seem as though the question we shall treat this year is *more special* than last year's question. It might seem that last year we studied the "infrastructure" of the child's understanding, the collection of processes that enable him to feel, perceive, and understand; whereas this year we are interested in a fairly narrow sector of this perception and understanding—the perception and understanding of others. It might seem that last year we were concerned with the psychology of understanding in the child, while this year we will concern ourselves with the much more limited subject of affectivity.

This, however, is not the relation between the two kinds of question. I do not at all believe that the question of relations with others is a

secondary and more particular problem, more strictly confined to affectivity than the problem with which we occupied ourselves last year.

The very results of last year's study prevent us from treating the problem of relations with others as secondary and subordinate.

In speaking of the child's perception or of causal relations as grasped by the child, what struck us was the fact that, in the case of the child's perception, it is not a matter of a simple reflection of external phenomena within the child or of a simple sorting of data resulting from the activity of the senses. It seemed to us to be a question of an actual "informing" [*Gestaltung*] of experience in the child. For example, in the case of causal relations, which have traditionally been thought to have been learned by an intellectual operation in the child, we have seen instead, with Michotte, that such relations are anchored in the child's very perception of external events and that perception in the child is not a simple reflection nor the result of a process of sorting data. Rather, it is a more profound operation whereby the child organizes his experience of external events—an operation which thus is properly neither a logical nor a predicative activity.

When we considered the child's imagination, it appeared likewise that we could not assimilate what is called the *image* in the child to a kind of degraded, weakened copy of preceding perceptions. What is called *imagination* is an emotional conduct. Consequently here again we found ourselves, as it were, *beneath* the relation of the knowing subject to the known object. We had to do with a primordial operation by which the child organizes the imaginary, just as he organizes the perceived.

When we examined the child's drawing, one of the faults we found with the famous book by Luquet was precisely this: The child's drawing is considered by Luquet to be an abortive adult drawing, and the development of the child, viewed through the stages of his drawing, appears as a series of frustrations of the attempt to represent the world as the adult does (at least the white, "civilized," Western adult)—that is, according to the laws of classical geometrical perspective. We tried to show, on the contrary, that the child's processes of expression could not be understood as simple breakdowns on the road to "visual realism" and that, instead, these processes testified to the presence in the child of a relation with things[a] and with the sensible very different from the one that is expressed in the perspective projection of drawing in the classic style.

Finally, it appeared to us, following certain indications of Wallon, that there is perhaps no place for the question of the child's conception of the world. In order to be able to speak of a conception of the world,

a. In the text "*droows*" appears to be a misprint for "*choses*."—Trans.

the child would actually have to totalize his experience under general concepts. But, as Wallon remarked, an entire sector of this experience is fragmentary [*lacunaire*] for the child; it contains what Wallon called "ultra things," i.e., entities of which the child has no direct experience, which are at the horizon of his perception—like the sun, the moon, etc. These entities remain for the child in a state of relative indetermination; he has, strictly speaking, no conception of them. With respect to nearby objects, the child often has a conception that is very close to that of the adult (Huang). The concepts of animism and of artificialism, employed a bit recklessly, are adult ways of expressing the child's confusion in the face of "ultra things"; they are the expedients sometimes used by the child in replying to the adult's questions and perhaps do not arise in his own experience.

All this, I believe, converged on the following idea: What classical academic psychology calls "functions of cognition"—intelligence, perception, imagination, etc.—when more closely examined, lead us back to an activity that is prior to cognition properly so called, a function of organizing experiences that imposes on certain totalities the configuration and the kind of equilibrium that are possible under the corporeal and social conditions of the child himself.

In another course, moreover, we examined the problem of the acquisition of language, and there again we reached the same kind of conclusion: The acquisition of language appeared to us to be the acquisition of an open system of expression. That is, such a system is capable of expressing, not some finite number of cognitions or ideas, but rather an indeterminate number of cognitions or ideas to come. The system that is speech is learned by the child, not at all by a genuine intellectual operation (as though by means of intelligence the child understood the principles of speech, its morphology, and its syntax). Rather, what is involved is a kind of *habituation*, a use of language as a tool or instrument. The employment of language, which is an effect and also one of the most active stimuli of intellectual development, does not appear to be founded on the exercise of pure intelligence but instead on a more obscure operation—namely, the child's assimilation of the linguistic system of his environment in a way that is comparable to the acquisition of any habit whatever: the learning of a structure of conduct.

These results lead us to think that between the functions of understanding we studied last year and affectivity itself there must be an altogether different relation than that of the simple subordination of the latter to the former.

However, I would like to show this more directly by means of two examples. First, recent studies have tended to show that even external

perception of sense qualities and space—at first glance the most disinterested, least affective of all the functions—is profoundly modified by the personality and by the interpersonal relationships in which the child lives. The second example has to do with the learning of language. Certain authors show that there is a very close and profound relation between the development of language and the configuration of the human environment in which the child develops.

1. *Psychological rigidity*

ON THE FIRST POINT, I have in mind the interesting work of Else Frenkel-Brunswik, described in an article entitled "Intolerance of Ambiguity as an Emotional and Perceptual Personality Variable." [3] This work is connected with a whole series of earlier studies. In particular, it recalls the work of the German psychologist Erich Jaensch, who twenty-five years ago was well known for his research on eidetic imagery [4] and who has since turned to research on perception designed to show a close relation between the way a person perceives objects and the general characteristics of his personality and, in particular, of his relations with others. Ambiguous perceptions (the same drawing of a cube seen now from one standpoint, now from another) would be more frequent in "liberal" subjects (meaning subjects who are likely to recognize several aspects of things even if, on first glance, these different aspects are not easily reconciled with one another). Actually the research by Jaensch is in this sense very hasty and bold. Mrs. Frenkel-Brunswik, on the contrary, endeavored to carry out a rigorous experimental study. She bases her approach firmly on the principle of projective techniques. Rorschach constructed his test on the idea that the subject's perception is entirely altered by his personality, since he relied on the subject's manner of perceiving certain visual data in order to deduce from it certain personality traits.

Mrs. Frenkel-Brunswik chose a precise personality trait in order to study its correlation with certain types of perception. She called this trait "psychological rigidity," and we are going to define it shortly. The author endeavored to study the correlation between this trait and certain modes of perception by means of an experimental method. A study was made by the University of California on 1500 schoolchildren between the ages of 11 and 16. Of these children she chose 120 who represented the extreme limiting-case of psychological rigidity. She submitted them to interviews, clinical examinations, and tests. The parents of these children were visited, and one third of them were

3. *Journal of Personality*, vol. 18 (September, 1949), pp. 108–43.

4. Cf. Erich Jaensch, *Eidetic Imagery and Typological Methods of Investigation*, trans. Oscar Oeser (New York, 1930).—*Trans.*

submitted to exact perceptual experiments of a kind designed to show the link between the type of perception and the personal and interpersonal factors I spoke of earlier.

The personality variable chosen for these experiments, "psychological rigidity," is a notion that originated in psychoanalysis, although it is far from being an orthodox Freudian conception. It means the attitude of the subject who replies to any question with black-and-white answers; who gives replies that are curt and lacking in any shading; who also is generally ill disposed, when examining an object or a person, to recognize in them any clashing traits; and who continually tries, in his remarks, to arrive at a simple, categorical, and summary view.

In the eyes of the author this "psychological rigidity" is by no means the sign of an actual psychological force, as people who know the subject sometimes believe. It is only a mask. Beneath this rigidity one could easily enough find real chaos or at least a deeply divided personality. Psychological rigidity, according to Mrs. Frenkel-Brunswik, is what the Freudians call a "reaction formation"; that is, a façade interposed by the subject between his psychological reality and others who are there to examine him. The principle of this formation is well known: If the individual is very aggressive he conceals his aggression under an acquired veil of politeness, and often the most apparently polite people are, at bottom, the most aggressive. The author brings to light the "reactional" character of rigidity. Rigid subjects are in reality, when more closely examined, likely to be profoundly divided in their personality dynamics. If they are questioned about their families, in general they reply with categorical affirmations. Either the family is perfection itself—one could not wish for a better—or it is horrible. In any case there are never any nuances. More often than not, such persons are traditionalists. They declare that their families—and their parents in particular—are perfect. For them their parents represent an absolute. What allows us to say that beneath this rigidity there is no psychological force or genuine conviction is this: First, when these subjects analyze and describe their parents, they always confine themselves to mentioning the inessential, external traits, as though they are afraid to enter into a more detailed analysis and to recognize imperfections in the persons around them. Second, each time one tries to catch them unawares and obtain responses whose real significance escapes them they are generally negative toward their parents. Instead of being asked directly what they think of their parents, they are asked, for example, to make a list of the people they would take along if they had to live for several years on a desert island. It is significant that many of them who are absolutely in favor of the family regularly exclude

their parents from the list. Third, when they are given the Thematic Apperception Test, one notices that their descriptions of their parents emphasize their coercive, punitive aspects. These different indications, when joined with the evidence from clinical experiments, permit us to say that their wholesale affirmation of the merits of the family is, rather, a mask behind which a fairly lively aggression may be found. When aggression against the parent figures becomes too urgent and agonizing, these subjects superimpose a phenomenon of reaction to that aggression. They systematically avoid lifting the mask; hence their refusal to admit shading into the picture of their parents. If they begin to admit any shading at all, they will admit too much.

In a more general way, not only with their parents but with regard to all moral and social problems as well, these subjects proceed by dichotomizing—the dichotomy of authority and obedience. The child must be absolutely obedient, or else the very principle of authority is called in question. Another example is the dilemma of cleanliness and dirtiness. The mania for cleanliness (a familiar trait) can make certain women into passionate house cleaners and fanatic polishers of furniture, etc. All this has its roots in the rigidity of the child. Thus we have the dualism of good and evil, virtue and vice, and even that of masculinity and femininity. Of course, nobody denies that each of these differences is considered to be an *absolute* difference, founded in nature, excluding any appearance of transition, degree, or change. Mrs. Frenkel-Brunswik thinks that these subjects have acquired this attitude in their initial relations with the family, inasmuch as these relations are also their first relations to values and to the world. The parents are the means by which they first communicate with the world. The families in question are usually authoritarian; they are the ones in which the child is strictly "trained," the "frustrating" families in which the child feels insecure and in danger.

Psychological rigidity can be found occasionally in all subjects, but it is only in an especially authoritarian environment that it becomes a constant conduct, of which the child cannot rid himself. In this kind of authoritarian atmosphere the child divides the parent figure in half. On the one hand there is the kindly image of his parents that is willingly avowed, and on the other there is the image he is struggling against. As Melanie Klein has said, two images (the "good mother" and the "bad mother"), instead of being united in relation to the same person, are arranged by the child with the former prominent and the latter completely concealed from himself. When questioned, the child overtly recognizes only the favorable image, and this is what, according to Melanie Klein, defines ambivalence. Ambivalence consists in having two alternative images of the same object, the same person, without making any effort to connect them or to notice that in reality they relate to the same object and the same person.

Melanie Klein has established a profound distinction between ambivalence of this kind and ambiguity. As opposed to ambivalence, ambiguity is an adult phenomenon, a phenomenon of maturity, which has nothing pathological about it. It consists in admitting that the same being who is good and generous can also be annoying and imperfect. Ambiguity is ambivalence that one dares to look at face to face. What is lacking in rigid subjects is this capacity to confront squarely the contradictions that exist in their attitudes toward others.

The families in which these children are found are authoritarian, as we have said, and they are equally the "socially marginal" families (here we are extending the social aspect of this phenomenon). There also exists a social marginalism in France. The *nouveau riche* is marginal in the sense that he is placed in a category in which he does not feel himself thoroughly integrated. It is the same with the "newly poor." This latter category is much more important in the United States because of its national minorities.

When conjoined with social conditions, rigidity has social consequences. Unaware of his double attitude, refusing even to recognize in himself the image of "bad parents," the rigid child tends to project outside himself the part of himself he does not want to be. The aggression he wants to be rid of is projected outside by a process of externalization that in certain cases is evident beyond any doubt.

According to the best observers, the legends in America and French Africa concerning the sexuality of Negroes display a mechanism of this type. Subjects project onto the Negro (considered to represent a "natural" sexuality that is stronger and more violent than their own) something of themselves that they would like not to have. The same mechanism is called into play with the Jews; the construction of the Jewish character often proceeds by a division of this kind. The anti-Semite throws off onto the Jew the part of himself he does not want and is most ashamed of, as others do with the Negro. This is true also of other minorities. The minority is all the more hateful for representing the behavior whose germs the subject carries within himself and will not admit are his own. Simone de Beauvoir has analyzed a mechanism of the same kind in the phenomenon of the "battle of the sexes."[5] From age ten on, this phenomenon appears in schools where boys and girls are reared together. If the boys and girls are asked the reasons for this social dichotomization (for this is what it already is), one is forced to admit something like this: Each attributes to the other the character-

5. Simone de Beauvoir, *The Second Sex*, trans. and ed. H. M. Parshley (New York, 1953).—*Trans.*

istics of his humanity that he does not want. For example, men who, by virtue of the established myths as well as certain tendencies of their own physiological constitutions, do not want to be weak and sensitive and want to be self-sufficient, decisive, and energetic, project on women exactly those personality traits they do not themselves want to have. Women, who are accomplices in this masquerade, from their side project on men the personality traits they wish to be rid of or are unable to assume. There is thus a mutual disparagement which is at the same time the basis of a pact concluded between the two sexes. The very women who proclaim their hatred of men also admit that it is, after all, men's business to make decisions, pay taxes, carry the bags to the station, and hold positions, etc. In reality it is scarcely necessary to say that even men are frivolous and capable of being mistaken; by the same token, women are as decisive as men and as capable of being in business or a profession. But by a sort of tacit agreement men and women are at the same time accomplices and enemies, and thus they continue to live side by side, in a love that is hate, a hate that is love.

It remains for us to see how the type of personality and of interpersonal relations designated by the term "psychological rigidity" express themselves in the anonymous functions of external perception. Let us now turn to the experiments designed to make evident the relation between psychological rigidity, as a mode of relation to self and others, and perception in its own right.

A study was made of 1500 schoolchildren between eleven and sixteen years old, and, in particular, of 120 of them who were remarkably "rigid." These subjects showed very strong racial and social prejudices—prejudices which, you recall from what we have already said, bear witness to a sort of interior schism between what the subjects admit and recognize in themselves and what they do not admit, do not recognize, and are unwilling to see in themselves. The latter traits are projected on external subjects who play the role of scapegoat; while, on the contrary, the subject appears in his own eyes as immune to the defects he finds in external groups.

The experimenters asked a certain number of questions designed to reveal psychological rigidity. Here are some examples of the test questions. Subjects were asked to evaluate the following phrase: "People can be divided into two categories—the weak and the strong." Or again, "Teachers should tell their students what to do, rather than trying to find out what the students want." This last sentence served to test for the authoritarian tendencies of the subjects. Again, "Girls should learn only about household matters." Another test sentence (this test was given in the United States) was "We should deport all

refugees and give their jobs to veterans." Finally, "There is only one way to do something properly." Psychologically rigid subjects agreed immediately with this last proposition.

After these tests for "rigidity," experiments were made to show the characteristic ways in which the subjects perceive. Psychologically rigid subjects could be expected to show, in the same way, a sort of perceptual rigidity. It would be hard for them to modify their attitude and to adopt a new account of new aspects of a problem. They would have a tendency to refer any new experience of a different type that might be presented to them back to already familiar experiences. For example, they were shown films in which the images gradually changed, e.g., the image of a dog transformed little by little into a cat. Members of the strongly prejudiced group held more firmly, in general, to their antecedent mode of perception and saw no appreciable change in the figure which was presented to them, even when the changes were already objectively noticeable.

In more general terms, such a subject rebels against all aspects of the phenomenon of transition. Even if, in effect, he is not immediately acquiescent to the changes in the stimuli that are presented to him, he might at least notice that something has changed. Without altering his perception of the whole he might, all the same, recognize that the figure is in the process of disorganization. But this recognition of the phenomenon of transition is exactly what is repugnant to him.

In sum, the subjects who carry within themselves extremely strong conflicts are precisely those who reject, in their views of external things, the admission that there are particular situations that are ambiguous, full of conflicts, and mixed in value. This occurs in such a way that one can say that a very strong emotional ambivalence shows up, at the level of understanding or perception, as a very weak ambiguity in the things perceived or in the subject's ideas of them. The more emotionally ambivalent the subject, the less it suits him that there should be any ambiguity in things and in his view of things. Emotional ambivalence is what demands the denial of intellectual ambiguity. In subjects whose intellectual ambiguity is strong it often happens that the emotional foundation is much more stable than in other subjects.

Another series of experiments was designed to measure the speed with which a subject adapts to a new type of problem. The subject was trained to solve a certain number of elementary tasks that implied a certain method of solution. He was then presented with other problems that were apparently of the same form but in reality could be solved much more easily by another method. Only, in order to find the other method, the subject must be supple and capable of responding to the situation in a way appropriate to its new content. One finds in the same

way that psychologically rigid subjects in general react against this modification of their techniques.

Here we must interject two remarks that are indispensable for an understanding of the exact scope of these investigations.

1. Mrs. Frenkel-Brunswik does not say that psychological rigidity, or rigidity in psycho-social relations, necessarily appears in an unequivocal manner in the domain of perception. The relation established by the author between affective life and intersubjectivity, on the one hand, and the functions of understanding or of perception, on the other, is much more subtle and fluid. There is always a relation between these two domains, but it is not always that of a single relation of analogy. There are subjects who, although psychologically rigid, *compensate for* that rigidity by great flexibility in the perceptual domain. The two phenomena always occur together, but they may be united in several different ways. Sometimes the same structure is met with in both domains—psychological rigidity appearing as perceptual rigidity—and sometimes, in other cases, the perceptual phenomenon compensates for (rather than simply resembles) the affective phenomenon. What is important in both cases, however, is that the two phenomena always comprise a single whole.

2. In outlining a social psychology of social and political opinions,[6] Mrs. Frenkel-Brunswik does not propose that psychology *alone* is in a position to solve political problems. There are, in her view, subjects who are without social prejudices of any kind, who are perfectly "liberal" in the sense that they admit that all men are brothers, that one cannot concentrate all the characteristics of evil in Negroes, Jews, or any other minority and yet who, for all that, are rigid subjects because they refuse to see among men even the most striking differences of *situation*—differences which pertain to the collectivity in which they have lived and received their initial training. There is an abstract or rigid liberalism which consists in thinking that all men are *identical*. There are also liberals who are truly liberal, in the sense that they conceive very well that there can be differences of historical situation among men and different cultural environments. This does not prevent them from treating each man (in so far as his situation permits him to be a man) like any other. But the fundamental identity of men does not close their eyes to the cultural differences which may develop and which must be understood in action, if they do not want to arrive at results that are sometimes contrary to the ones they aimed for.

6. Cf. Else Frenkel-Brunswik and R. N. Sanford, "Some Personality Factors in Anti-Semitism," *Journal of Personality*, vol. 20 (1945), pp. 271–91. Merleau-Ponty cites at this point a partial French translation of this article under the title "La personnalité antisémite," which appeared in *Les Temps Modernes*, no. 60 (October, 1950).—*Trans.*

Racist opinions, on the other hand, are necessarily linked to psychological rigidity, since they rest on a myth and can thus be explained only by a psychological mechanism. But most political opinions, unlike these, are not reducible to psychological factors. Not every political question can be cut short with a psychological analysis. What betrays psychological rigidity is not the adoption of this or that conception of the state or of history; it is the *manner* in which one adopts this thesis and tries to justify it. Similarly, what characterizes a psychologically mature subject for Mrs. Frenkel-Brunswik is not that he does or does not have ambiguities; it is the *way in which he treats his ambiguities*. If he hides them from himself, if he flees them, if he does not confront them, he is psychologically rigid. If, on the contrary, he faces them squarely, he has arrived at maturity. Everyone is ambiguous in one way or another; it is just that there are subjects who refuse to take into account, to "interiorize," their ambiguities. This is ambivalence properly so called. Other subjects consent to see problems that arise on account of the discordant traits that are to be found in each and every individual.

To appreciate thoroughly the nature of anti-Semitism or prejudice against Negroes, it is not enough merely to be a psychologist, any more than an appreciation of this or that political doctrine necessarily requires a psychological study of those who adopt it. Psychology describes conducts; it cannot inform us about the internal content of the theses to which they address themselves. It can only describe attitudes.

My aim, as well as the aim of the author whose work I have been utilizing, has not been to show that the cognitive functions, like perception, are *explained* by the social structure in which the individual finds himself and in which he has the task of adjusting his perception to his environment and vice versa. The question of causality is not resolved by these investigations. They merely establish a correlation between the manner of perceiving and that of structuring the social world. But this correlation can be understood in two ways. On the one hand, we might decide that it is because the subject perceives in a rigid fashion (on account of his constitutional make-up) that he is predisposed in social matters to a dichotomization of things and to the prejudices I have already mentioned. On the other hand, one might decide that it is because the subject has organized his relations with others and with the social world in this or that way that he is brought to perceive them in the same way. The establishment of a correlation does not allow us to resolve this issue.

What must be understood, moreover, is that the question of a causal sequence of the two phenomena is *meaningless*. For it to be meaningful would require that the two phenomena be capable of stand-

ing in isolation. But this is never the case. In fact, from the time of his birth the child who will have prejudices has been molded by his environment, and in that respect has undergone a certain exercise of parental authority. Consequently there is no moment at which you could grasp, in a pure state, his way of perceiving, completely apart from the social conditioning that influences him. Inversely, you can never say that the way in which the child structures [*met en forme*] his social environment is unrelated to the hereditary or constitutional dispositions of his nervous system. He himself is the one who structures his surroundings, after all. It is as though there is in the child a sort of elasticity that sometimes makes him react to the influences of his surroundings by finding his own solutions to the problems they pose. And so the internal characteristics of the subject always intervene in his way of establishing his relations with what is outside him. It is never simply the outside which molds him; it is he himself who takes a position in the face of the external conditions. If, therefore, we refuse to answer yes or no to the problem of causality, it is not simply because we lack necessary information; rather, it is for reasons of principle. It is because, in fact and in principle, it is impossible to establish a cleavage between what will be "natural" in the individual and what will be acquired from his social upbringing. In reality the two orders are not distinct; they are part and parcel of a single global phenomenon.

Consequently our aim has not been to connect the functions of intellect to the subject's relation to society, as they depended on it in an unequivocal way, but to bring to light the profound relation of the two phenomenal orders that are part of a single global project of the individual—a global project in which are established his relations with the neutral perceptual fields that can be given in his experience, as well as his relations with his human and social surroundings.

2. *Affectivity and language*

I PASS to the second fact that appeared to me to be worthy of mention by way of introduction to this course: the relation that can be established between the development of intelligence (in particular, the acquisition of language) and the configuration of the individual's affective environment.

I call your attention to a short article by François Rostand entitled "*Grammaire et affectivité*."[7] Rostand begins by remarking that from the start there is a correlation between the age at which the child is most dependent on his parents (i.e., about two years) and the age at

7. *Revue Française de Psychanalyse*, vol. 14 (April-June, 1950), pp. 299-310.

which he begins to learn language. There is a period when the child is "sensitive" with regard to language, when he is capable of learning to speak. It has been shown that if the child up to two years of age does not have a linguistic model to imitate, if he does not find himself in an environment in which people are speaking, he will never speak as do those who have learned language during the period in question. This is the case with those children who are called "savages," who have been raised by animals or far from contact with speaking subjects. In no case have these subjects ever learned to speak with the linguistic perfection that is found among ordinary subjects. Deaf children whose retraining has been delayed and who consequently have not learned to speak during the "sensitive" period never speak their language in exactly the same way as do those who can hear. One can show, in fact, that in their syntax or their morphology there exist, after retraining, some very odd peculiarities: for example, the absence or rarity of the passive voice in verbs. This allows us to presume that there will be a profound link between the acquisition of language (which would seem to be a strictly intellectual operation) and the child's place in the family environment. It is this relation that Rostand seeks to define exactly.

It is a commonplace that the child's acquisition of language is also correlated with his relation to his mother. Children who have been suddenly and forcibly separated from their mothers always show signs of a linguistic regression. At bottom, it is not only the word "mama" that is the child's first; it is the entire language which is, so to speak, maternal.

The acquisition of language might be a phenomenon of the same kind as the relation to the mother. Just as the maternal relation is (as the psychoanalysts say) a relation of *identification*, in which the subject projects on his mother what he himself experiences and assimilates the attitudes of his mother, so one could say that the acquisition of language is itself a phenomenon of identification. To learn to speak is to learn to play a series of *roles*, to assume a series of conducts or linguistic gestures.

Rostand mentions an observation made by Dr. Dolto-Marette in a case of jealousy in a child. The younger of two children shows jealousy when his new brother is born. During the first days of the newborn child's life, he identifies with it, carrying himself as though he himself were the newborn baby. There is a striking regression in language as well as in character. In the following days one notices in him a change of attitude. The subject identifies himself with his older brother and overcomes his jealousy; he adopts all the characteristics of the eldest, including an attitude toward the new baby that is identical to what, until now, had been his older brother's attitude toward him. Thanks to

a fortunate circumstance his jealousy is overcome. By chance, just as the baby is born, a fourth child comes to stay in the family. This fourth child is bigger than all three brothers in the family. The presence of a child who is older than the eldest brother robs the latter of his status as the "absolute eldest." The eldest is now no longer "absolutely big," since there are others who are bigger than he is. The fourth child aids in the middle brother's transition and assimilation of the role of the eldest.

It is in this way that a case of neurotic stuttering is cured and a marked linguistic progress realized from day to day. The subject acquires the use of the simple past tense, the imperfect, the simple future, and the future with the verb *to go* ("I am *going to* leave"). Coming back to this observation, Rostand interprets it in the following fashion: The jealousy that invades the subject when he confirms the arrival of a new brother is essentially a refusal to change his situation. The newcomer is an intruder and is going to confiscate to his own advantage the place in the family that was held until now by our jealous subject. It is in the phase of the "surpassing" of jealousy that one notices the appearance of a link between the affective phenomenon and the linguistic phenomenon: jealousy is overcome thanks to the constitution of a scheme of past-present-future. In effect, jealousy in this subject consists in a rigid attachment to his present—that is, to the situation of the "latest born" which was hitherto his own. He considered the present to be absolute. Now, on the contrary, one can say that from the moment when he consents to be no longer the latest born, to become in relation to the new baby what his elder brother had until then been in relation to him, he replaces his attitude of "my place has been taken" with another, whose schema might be somewhat like this: "I *have been* the youngest, but I *am* the youngest no longer, and I *will become* the biggest." One sees that there is a solidarity between the acquisition of this temporal structure, which gives a meaning to the corresponding linguistic instruments, and the situation of a jealousy that is overcome. For the subject the situation of jealousy is the occasion both for re-structuring his relations with the others he lives with and at the same time for acquiring new dimensions of existence (past, present, and future) with a supple play among them.

Speaking Piaget's language, one might say that the whole problem of overcoming jealousy is a problem of "de-centering." Until now the subject has been centered on himself, centered on the situation of the latest born that he has occupied. In order to accept the birth of a new child, he must de-center himself. But the de-centering involved here is not, as it was for Piaget, a primarily intellectual operation, a phenomenon of pure knowledge. It is a matter of a lived de-centering, aroused by the situation of the child inside the family constellation.

One might even say that what the child learns, in solving the problem of jealousy, is to relativize his notions. He must relativize the notions of the youngest and the eldest: he is no longer *the* youngest; it is the new child who assumes this role. He thus must come to distinguish the absolute "youngest" from the relative "youngest" which he now becomes. And in the same way he must learn to become the eldest in relation to the newborn child, whereas until now the notion of "eldest" had only an absolute meaning.

In Piaget's language, the child must learn to think in terms of reciprocity. Rostand himself cites Piaget's terms. But these terms take on a new meaning from the fact that training in reciprocity, relativity, and de-centering occurs here not by intellectual acts of "grouping" but by operations within the vital order, by the manner in which the child restores [*réétablit*] his relations with others.

To this preliminary observation Rostand adds the following personal one: He noticed in a little girl of thirty-five months an interesting linguistic phenomenon that followed a frightening emotional experience (an encounter, while walking alone, with a big dog). Two months later this experience seemed to bear fruit. There was an abrupt acquisition of certain modes of expression (in particular, the imperfect tense of verbs) which until then the child had not used.

This step occurred at the birth of a younger brother. What we have to understand is the exact relation between this linguistic phenomenon, the birth of the younger brother, and the emotional experience of two months earlier.

The child had come across a dog who was nursing its young. At the time she encountered the dog, she knew already from her parents that she was going to have a little brother or sister in about two months. Meeting the dog which was nursing its litter was not an indifferent experience for the child; it was a visible symbol of something analogous that was about to happen in her own world. The pattern about to be realized two months later in the child's environment (parents, little girl, little brother) was already prefigured by the pattern (big dog; me, the little girl; the little dogs). The sight of the dogs was of paramount significance by virtue of its relation to the situation in which the child was about to find herself.

In order for her to accept the birth of a younger brother, what was basically necessary was a change of attitude. Whereas the little girl had been, until then, the object of all attention and of all caresses, she now had to accept the fact that some of this attention and these caresses would be transferred to another, and to associate herself with this attitude. She had to pass from an ingratiating [*captative*] attitude (i.e., one in which the child receives without giving) to a selfless

[*oblative*], quasi-maternal attitude toward the child about to be born. It was necessary for her to accept a relative abandonment, to turn and confront a life that would henceforth be *her* life, that would no longer be supported, as it had been until then, by the exclusive attention of her parents. In short, the girl had to adopt an active attitude, whereas until then her attitude had been passive.

The linguistic phenomenon that emerges at this same time can be understood in this perspective. I said earlier that the imperfect tense appeared in the child's language after the birth of her brother. More important, however, was the emergence of four verbs in the future tense; there was also a great increase in the use of "me" and "I." If the future is a time of aggressiveness, a time when projects are envisioned, when one takes a stand in the face of what is to come and, instead of allowing it to come, moves actively toward it—then how was it made possible by the new situation of the little girl? The answer is that this was precisely the attitude demanded of the child by the birth of her brother. The acquisition of "me" and "I" presented no problems; it indicated that the subject adopted a more personal attitude and lived to a relatively greater degree by herself. Finally, the acquisition of the imperfect tense at the birth of her little brother indicated that the child was becoming capable of understanding that the present changes into the past. The imperfect is a former present which, moreover, is still referred to as present, unlike the past definite.[8] The imperfect is "still there." The acquisition of the imperfect thus presupposes a concrete grasp of the movement from present to past which the child, on her part, was just in the process of achieving in her relations with her family. The fact is, all the verbs she used in the imperfect after the birth of her brother had to do with the baby. The baby *is* what the elder sister *used to be* in the world of the family.

To be sure, emotion plays a role only to the extent that it gives the subject the occasion to re-structure her relations with her human environment, and not at all simply as emotion. If the problem had not been resolved, if the subject had shown herself incapable of overcoming her jealousy or her uneasiness, nothing good would have come from the experience. Inversely, there can be cases in which the subject progresses in language without apparent emotion. In such cases, however, linguistic progress always has an interrupted character; the acquisition of the modes of expression always represents a sort of crisis, in which a whole realm of expression is annexed in a single stroke.

In sum, the intellectual elaboration of our experience of the world is constantly supported by the affective elaboration of our inter-human

8. The difference in question here is that between, e.g., "I was going" (imperfect) and "I went" (past definite).—*Trans.*

relations. The use of certain linguistic tools is mastered in the play of forces that constitute the subject's relations to his human surroundings. The linguistic usage achieved by the child depends strictly on the "position" (in psychoanalytic terms) that is taken by the child at every moment in the play of forces in his family and his human environment.

Here again it is not a question of a causal analysis. There is no question of saying that the linguistic progress is *explained* by the affective progress, in the sense in which expansion is explained by heat. One might reply that the affective progress itself is also a function of the intellectual progress and that the entire intellectual development makes possible a certain affective progress. And this would also be true.

What we are seeking here is not a causal explanation, any more than before. My effort is to show the solidarity and unity of the two phenomena, not to reduce the one to the other, as is traditionally done by both empiricist and intellectualist psychologists. The child's experience of the constellation of his own family does more than impress on him certain relations between one human being and another. At the same time that the child is assuming and forming his family relations, an entire form of thinking arises in him. It is a whole usage of language as well as a way of perceiving the world.

[1] The Problem of the Child's Perception of Others: The Theoretical Problem

Before studying the different relations established between the child and his parents, his peers, other children, brothers, sisters, or strangers, before undertaking a description and analysis of these different relations, a question of principle arises: How and under what conditions does the child come into contact with others? What is the nature of the child's relations with others? How are such relations possible from the day of birth on?

Classical psychology approached this problem only with great difficulty. One might say that it was among the stumbling blocks of classical psychology because it is admittedly incapable of being solved if one confines oneself to the theoretical ideas that were elaborated by academic psychology.

How does such a problem arise for classical psychology? Given the presuppositions with which that psychology works, given the prejudices it adopted from the start without any kind of criticism, the relation with others becomes incomprehensible for it. What, in fact, is the

psyche [*psychisme*]—mine or the other's—for classical psychology? All psychologists of the classical period are in tacit agreement on this point: the psyche, or the psychic, is *what is given to only one person*. It seems, in effect, that one might admit without further examination or discussion that what constitutes the psyche in me or in others is something incommunicable. I alone am able to grasp my psyche—for example, my sensations of green or of red. You will never know them as I know them; you will never experience them in my place. A consequence of this idea is that the psyche of another appears to me as radically inaccessible, at least in its own existence. I cannot reach other lives, other thought processes, since by hypothesis they are open only to inspection by a single individual: the one who owns them.

Since I cannot have direct access to the psyche of another, for the reasons just given, I must grant that I seize the other's psyche only indirectly, mediated by its bodily appearances. I see you in flesh and bone; you are there. I cannot know what you are thinking, but I can suppose it, guess at it from your facial expressions, your gestures, and your words—in short from a series of bodily appearances of which I am only the witness.

The question thus becomes this: How does it happen that, in the presence of this mannequin that resembles a man, in the presence of this body that gesticulates in a characteristic way, I come to believe that it is inhabited by a psyche?[9] How am I led to consider that this body before me encloses a psyche? How can I perceive across this body, so to speak, another's psyche? Classical psychology's conception of the body and the consciousness we have of it is here a second obstacle in the way of a solution of the problem. Here one wants to speak of the notion of *cenesthesia*, meaning a mass of sensations that would express to the subject the state of his different organs and different bodily functions. Thus my body for me, and your body for you, could be reached, and be knowable, by means of a cenesthesic sense.

A mass of sensations, by hypothesis, is as *individual* as the psyche itself. That is to say, if in fact my body is knowable by me only through the mass of sensations it gives me (a mass of sensations to which you obviously have no access and of which we have no concrete experience), then the consciousness I have of my body is impenetrable by you. You cannot represent yourself in the same way in which I feel my own body; it is likewise impossible for me to represent to myself the way in which you feel your body. How, then, can I suppose that, in back of this appearance before me, there is someone who experiences his body as I experience mine?

9. I use the vague term "psyche" on purpose, in order to avoid any theory of consciousness that might be implied by a more precise term.

Only one recourse is left for classical psychology—that of supposing that, as a spectator of the gestures and utterances of the other's body before me, I consider the totality of signs thus given, the totality of facial expressions this body presents to me, as the occasion for a kind of decoding. Behind the body whose gestures and characteristic utterances I witness, I project, so to speak, what I myself feel of my own body. No matter whether it is a question of an actual association of ideas or, instead, a judgment whereby I interpret the appearances, I transfer to the other the intimate experience I have of my own body.

The problem of the experience of others poses itself, as it were, in a system of four terms: (1) myself, my "psyche"; (2) the image I have of my body by means of the sense of touch or of cenesthesia, which, to be brief, we shall call the "introceptive image" of my own body; (3) the body of the other as seen by me, which we shall call the "visual body"; and (4) a fourth (hypothetical) term which I must re-constitute and guess at—the "psyche" of the other, the other's feeling of his own existence—to the extent that I can imagine or suppose it across the appearances of the other through his visual body.

Posed thus, the problem raises all kinds of difficulties. First, there is the difficulty of relating my knowledge or experience of the other to an association, to a judgment by which I would project into him the data of my intimate experience. The perception of others comes relatively early in life. Naturally we do not at an early age come to know the exact *meaning* of each of the emotional expressions presented to us by others. This exact knowledge is, if you like, late in coming; what is much earlier is the very fact that I perceive an expression, even if I may be wrong about what it means exactly. At a very early age children are sensitive to facial expressions, e.g., the smile. How could that be possible if, in order to arrive at an understanding of the global meaning of the smile and to learn that the smile is a fair indication of a benevolent feeling, the child had to perform the complicated task I have just mentioned? How could it be possible if, beginning with the visual perception of another's smile, he had to compare that visual perception of the smile with the movement that he himself makes when he is happy or when he feels benevolent—projecting to the other a benevolence of which he would have had intimate experience but which could not be grasped directly in the other? This complicated process would seem to be incompatible with the relative precociousness of the perception of others.

Again, in order for projection to be possible and to take place, it would be necessary for me to begin from the analogy between the facial expressions offered me by others and the different facial gestures I execute myself. In the case of the smile, for me to interpret the visible

smile of the other requires that there be a way of comparing the visible smile of the other with what we may call the "motor smile"—the smile as felt, in the case of the child, by the child himself. But in fact do we have the means of making this comparison between the body of the other, as it appears in visual perception, and our own body, as we feel it by means of introception and of cenesthesia? Have we the means of systematically comparing the body of the other as seen by me with my body as sensed by me? In order for this to be possible there would have to be a fairly regular correspondence between the two experiences. The child's visual experience of his own body is altogether insignificant in relation to the kinesthetic, cenesthesic, or tactile feeling he can have of it. There are numerous regions of his body that he does not see and some that he will never see or know except by means of the mirror (of which we will speak shortly). There is no point-for-point correspondence between the two images of the body. To understand how the child arrives at assimilating the one to the other, we must, rather, suppose that he has other reasons for doing it than reasons of simple detail. If he comes to identify as bodies, and as animated ones, the bodies of himself and the other, this can only be because he globally identifies them and not because he constructs a point-for-point correspondence between the visual image of the other and the introceptive image of his own body.

These two difficulties are particularly apparent when it comes to accounting for the phenomenon of imitation. To imitate is to perform a gesture in the image of another's gesture—like the child, for example, who smiles because someone smiles at him. According to the principles we have been entertaining, it would be necessary for me to translate my visual image of the other's smile into a motor language. The child would have to set his facial muscles in motion in such a way as to reproduce the visible expression that is called "the smile" in another. But how could he do it? Naturally he does not have the other's internal motor feeling of his face; as far as he is concerned, he does not even have an image of himself smiling. The result is that if we want to solve the problem of the transfer of the other's conduct to me, we can in no way rest on the supposed analogy between the other's face and that of the child.

On the contrary, the problem comes close to being solved only on condition that certain classical prejudices are renounced. We must abandon the fundamental prejudice according to which the psyche is that which is accessible only to myself and cannot be seen from outside. My "psyche" is not a series of "states of consciousness" that are rigorously closed in on themselves and inaccessible to anyone but me. My consciousness is turned primarily toward the world, turned toward

things; it is above all a relation to the world. The other's consciousness as well is chiefly a certain way of comporting himself toward the world. Thus it is in his conduct, in the manner in which the other deals with the world, that I will be able to discover his consciousness.

If I am a consciousness turned toward things, I can meet in things the actions of another and find in them a meaning, because they are themes of possible activity for my own body. Guillaume, in his book *l'Imitation chez l'enfant*,[10] says that we do not at first imitate others but rather the actions of others, and that we find others at the point of origin of these actions. At first the child imitates not persons but conducts. And the problem of knowing how conduct can be transferred from another to me is infinitely less difficult to solve than the problem of knowing how I can represent to myself a psyche that is radically foreign to me. If, for example, I see another draw a figure, I can understand the drawing as an action because it speaks directly to my own unique motility. Of course, the other *qua* author of a drawing is not yet a whole person, and there are more revealing actions than drawing—for example, using language. What is essential, however, is to see that a perspective on the other is opened to me from the moment I define him and myself as "conducts" at work in the world, as ways of "grasping" the natural and cultural world surrounding us.

But this presupposes a reform not only of the notion of the "psyche" (which we will replace henceforth by that of "conduct") but also of the idea we have of our own body. If my body is to appropriate the conducts given to me visually and make them its own, it must itself be given to me not as a mass of utterly private sensations but instead by what has been called a "postural," or "corporeal, schema." This notion, introduced long ago by Henry Head, has been taken over and enriched by Wallon, by certain German psychologists, and has finally been the subject of a study in its own right by Professor Lhermitte in *l'Image de notre corps*.[11]

For these authors, my body is no agglomeration of sensations (visual, tactile, "tenesthesic," or "cenesthesic"). It is first and foremost a *system* whose different introceptive and extroceptive aspects express each other reciprocally, including even the roughest of relations with surrounding space and its principal directions. The consciousness I have of my body is not the consciousness of an isolated mass; it is a *postural schema*. It is the perception of my body's position in relation to the vertical, the horizontal, and certain other axes of important coordinates of its environment.

In addition, the different sensory domains (sight, touch, and the

10. Paris, 1925.
11. Paris, 1939.

sense of movement in the joints) which are involved in the perception of my body do not present themselves to me as so many absolutely distinct regions. Even if, in the child's first and second years, the translation of one into the language of others is imprecise and incomplete, they all have in common a certain *style* of action, a certain *gestural* meaning that makes of the collection an already organized totality. Understood in this way, the experience I have of my own body could be transferred to another much more easily than the cenesthesia of classical psychology, giving rise to what Wallon calls a "postural impregnation" of my own body by the conducts I witness.

I can perceive, across the visual image of the other, that the other is an organism, that that organism is inhabited by a "psyche," because the visual image of the other is interpreted by the notion I myself have of my own body and thus appears as the visible envelopment of another "corporeal schema." My perception of my body would, so to speak, be swallowed up in a cenesthesia if that cenesthesia were strictly individual. On the contrary, however, if we are dealing with a schema, or a system, such a system would be relatively transferrable from one sensory domain to the other in the case of my own body, just as it could be transferred to the domain of the other.

Thus in today's psychology we have one system with two terms (my behavior and the other's behavior) which functions as a whole. To the extent that I can elaborate and extend my corporeal schema, to the extent that I acquire a better organized experience of my own body, to that very extent will my consciousness of my own body cease being a chaos in which I am submerged and lend itself to a transfer to others. And since at the same time the other who is to be perceived is himself not a "psyche" closed in on himself but rather a conduct, a system of behavior that aims at the world, he offers himself to my motor intentions and to that "intentional transgression" (Husserl) by which I animate and pervade him. Husserl said that the perception of others is like a "phenomenon of coupling" [*accouplement*]. The term is anything but a metaphor. In perceiving the other, my body and his are coupled, resulting in a sort of action which pairs them [*action à deux*]. This conduct which I am able only to see, I live somehow from a distance. I make it mine; I recover [*reprendre*] it or comprehend it. Reciprocally I know that the gestures I make myself can be the objects of another's intention. It is this transfer of my intentions to the other's body and of his intentions to my own, my alienation of the other and his alienation of me, that makes possible the perception of others.

All these analyses presuppose that the perception of others cannot be accounted for if one begins by supposing an ego and another that are *absolutely* conscious of themselves, each of which lays claim, as a result, to an absolute originality in relation to the other that confronts it. On the contrary, the perception of others is made comprehensible if one supposes that psychogenesis begins in a state where the child is unaware of himself and the other as different beings. We cannot say that in such a state the child has a genuine communication with others. In order that there be communication, there must be a sharp distinction between the one who communicates and the one with whom he communicates. But there is initially a state of pre-communication (Max Scheler), wherein the other's intentions somehow play *across* my body while my intentions play across his.

How is this distinction made? I gradually become aware of my body, of what radically distinguishes it from the other's body, at the same time that I begin to live my intentions in the facial expressions of the other and likewise begin to live the other's volitions in my own gestures. The progress of the child's experience results in his seeing that his body is, after all, closed in on itself. In particular, the visual image he acquires of his own body (especially from the mirror) reveals to him a hitherto unsuspected isolation of two subjects who are facing each other. The objectification of his own body discloses to the child his difference, his "insularity," and, correlatively, that of others.

Thus the development has somewhat the following character: There is a first phase, which we call pre-communication, in which there is not one individual over against another but rather an anonymous collectivity, an undifferentiated group life [*vie à plusieurs*]. Next, on the basis of this initial community, both by the objectification of one's own body and the constitution of the other in his difference, there occurs a segregation, a distinction of individuals—a process which, moreover, as we shall see, is never completely finished.

This kind of conception is common to many trends in contemporary psychology. One finds it in Guillaume and Wallon; it occurs in Gestalt theorists, phenomenologists, and psychoanalysts alike.

Guillaume shows that we must neither treat the origin of consciousness as though it were conscious, in an explicit way, of itself nor treat it as though it were completely closed in on itself. The first *me* is, as he says, virtual or latent, i.e., unaware of itself in its absolute difference. Consciousness of oneself as a unique individual, whose place can be taken by no one else, comes later and is not primitive. Since the primordial *me* is virtual or latent, egocentrism is not at all the attitude of a *me* that expressly grasps itself (as the term "egocentrism" might lead us to believe). Rather, it is the attitude of a *me* which is unaware of itself and lives as easily in others as it does in itself—but which, being unaware of others in their own separateness as well, in truth is no more conscious of them than of itself.

Wallon introduces an analogous notion with what he calls "syncretic sociability." Syncretism here is the indistinction between me and the other, a confusion at the core of a situation that is common to us both. After that the objectification of the body intervenes to establish a sort of wall between me and the other: a partition. Henceforth it will prevent me from confusing myself with what the other thinks, and especially with what he thinks of me; just as I will no longer confuse him with my thoughts, and especially my thoughts about him. There is thus a correlative constitution of me and the other as two human beings among all others.

Thus at first the *me* is both entirely unaware of itself and at the same time all the more demanding for being unaware of its own limits. The adult *me*, on the contrary, is a *me* that knows its own limits yet possesses the power to cross them by a genuine sympathy that is at least *relatively* distinct from the initial form of sympathy. The initial sympathy rests on the ignorance of oneself rather than on the perception of others, while adult sympathy occurs between "other" and "other"; it does not abolish the differences between myself and the other.

[2] The Placement of the Corporeal Schema and the First Phases of a Perception of Others (from Birth to Six Months)

What has been gained from these introductory remarks has been the correlation between consciousness of one's own body and perception of the other. To be aware that one has a body and that the other's body is animated by another psyche are two operations that are not simply logically symmetrical but form a real system. In both cases it is a question of becoming conscious of what might be called "incarnation." To notice, on the one hand, that I have a body which can be seen from outside and that for others I am nothing but a mannequin, gesticulating at a point in space and, on the other hand, to notice that the other has a psyche—i.e., that this body I see before me like a mannequin gesticulating at a point in space is animated by another psyche—are two moments of a single whole. This does not mean that the child's experience of this total phenomenon can assign a privilege to one of these aspects; rather, any progress realized in one aspect unbalances the totality and is the dialectical ferment that results in subsequent progress in the system. They are complementary operations, and the experience of my body and the body of the other form a totality and constitute a "form." In saying this, naturally I do not mean

that the perception of others and the perception of one's own body always go hand in hand or that they develop at the same pace. On the contrary, we shall see that the perception of one's own body is ahead of the recognition of the other, and consequently if the two comprise a system, it is a system that becomes articulated in time. To say that a phenomenon is one of "form" (*Gestalt*) is in no way to say that it is innate in its different aspects or even in a single one of its aspects. Rather, it is to say that it develops according to a law of *internal* equilibrium, as if by *auto-organization*. Gestalt theorists have by no means limited the use of the notion of "form" to the instant or the present. They have, on the contrary, insisted on the phenomenon of form in time (melody). I said that perception of one's own body comes earlier than perception of the other. The child takes notice of his own body sooner than he does of the expressions of the other. That does not prevent the two phenomena from being internally linked. The perception of one's own body creates an imbalance as it develops: through its echo in the image of the other, it awakens an appeal to the forthcoming development of the perception of others. It echoes in another phase, in which the perception of others appears predominant, and so on throughout the development. The two phenomena can easily form a system, although they are emphasized only successively. Each of the phases of this development contains the germs which prepare the way for its being surpassed. And to say that the phenomenon is a formal one is by no means to say that it is, in each of its stages, completely at rest. Any form (e.g., those we perceive in space—colored forms) is actually subject to a play of forces from different directions. The imbalance can be infinitesimal at first and give rise to no appreciable change. Then when it passes a certain limit, a change occurs. In the same way there may well be something at the core of each phase of development which anticipates the next phase and which gives life to a series of re-structurations. The notion of form is essentially dynamic.

Let us now consider the state of the perception of one's own body and the state of the perception of others, each in its turn.

1. *One's own body from birth to six months*

The body, as Henri Wallon suggests in his excellent analysis in *Les origines du caractère chez l'enfant*,[12] begins by being introceptive. At the beginning of life there emerges an entire phase in which extroceptivity (i.e., vision, hearing, and all other perceptions relating to the external world), even if it begins to operate, cannot in any case do so in collaboration with introceptivity. At this age the latter is the

[12] 2nd edition (Paris, 1949).

best organized means for bringing us into relation with things. In the earliest stage of the child's life, external perception is impossible for very simple reasons: visual accommodation and muscular control of the eyes are insufficient.

As has often been said, the body is at first "buccal" in nature. Stern has even spoken of a "buccal space" at the beginning of the child's life, meaning by this that the limit of the world for the child is the space that can be contained in, or explored by, his mouth. One could say more generally, as Wallon does, that the body is already a respiratory body. Not only the mouth but the whole respiratory apparatus gives the child a kind of experience of space. After that, other regions of the body intervene and come into prominence. All the regions linked to the functions of expression, for example, acquire an extreme importance in the months that follow. In waiting for the union that will arise between the data of external perception and those of introceptivity, the introceptive body functions as extroceptive. In another context, this is what psychoanalysts say about the origin of the child's experiences when they show, for example, that the child's relations to the mother's breast are his first relations with the world.

It is only between the third and the sixth month that a union occurs between the introceptive and the extroceptive domains. The different neural paths are not yet ready to function at birth. Myelinization, which makes their functioning possible, is late in taking place; this is particularly true of the connective fibers we speak of at present. It occurs between the third and the sixth month, connecting the mechanisms which furnish the various sensory data as well as those which correspond respectively to extroceptivity and introceptivity.

Up to that moment perception is impossible for yet another reason: it presupposes a minimal bodily equilibrium. The operation of a postural schema—that is, a global consciousness of my body's position in space, with the corrective reflexes that impose themselves at each moment, the global consciousness of the spatiality of my body—all this is necessary for perception (Wallon). In fact the effort at equilibrium continually accompanies all our perceptions except when we are lying on our back. But also, observes Wallon, it is above all in this position that the child's thinking and perception fade away; he falls asleep. This link between motility and perception shows at what point it is true to say that the two functions are only two aspects of a single totality and that the perception of one's entry into the world and of one's own body form a system.

When the necessary neural paths have been acquired, there remains a considerable gap between the precision of the consciousness of the body in certain domains and in others. You know, for example, that

myelinization occurs much later in the nerve fibers corresponding to the activity of the feet than it does in those which correspond to the activity of the hands. The delay is about three weeks long. All the same, in the case of the hands there is a slight lag of about twenty-six days in the myelinization of the left hand as compared with the right. Consequently there is a phase in which the child calls up the physiological conditions for a precise perception of the right hand's movements but not yet those for a precise perception of the movements of the left hand.

It is not surprising, therefore, that the child does not really interest himself in his body or in its parts until relatively late. It is only on the 115th day of his life, or around the fourth month, that one notices the child actually paying attention to his right hand. Only in the twenty-third week of life, or around the sixth month, does one find the child systematically making the experiment of exploring one hand with the other. At that moment—having clasped his right hand with his left hand, for example—he interrupts his movement and looks attentively at his hands. At the twenty-fourth week, or at the end of the sixth month, the child is perplexed at the sight of a glove placed next to his hand. He is seen comparing the glove and his hand, looking attentively at the moving hand. All these experiments are aimed at familiarizing the child with the correspondence between the hand which touches and the hand which is touched, between the body as seen and the body as felt by introceptivity.

The consciousness of one's own body is thus fragmentary [*lacunaire*] at first and gradually becomes integrated; the corporeal schema becomes precise, restructured, and mature little by little.

2. *The other from birth to six months*

THIS ENTIRE PLACEMENT [*mise en place*] of the corporeal schema is at the same time a placing of the perception of others. Reactions to others, according to Guillaume in *l'Imitation chez l'enfant*, are extremely precocious. To tell the truth, it seems that the first forms of reaction to others described by Guillaume are not connected with a visual perception of others; they correspond, rather, to the data of introceptivity. Guillaume says that between the ninth and the eleventh day, he noticed an astonished and attentive expression in the child, directed toward faces and fleeting smiles. At sixteen days he found differences in the attitude of the child according to whether he was in the arms of his mother, his wet nurse, or his father.

In Wallon's view, it is not a question, in these different attitudes, of a veritable extroceptive perception of the mother, the father, and the

nurse. Instead it is a question of differences felt by the child in the state of his body—differences in his well-being according to whether the nurse's breast is present or absent and also according to the way in which the child is held in the arms of each of the persons involved.

Up to the age of three months, according to Wallon, there is no external perception of others by the child, and what ought to be concluded when, for example, the child is seen to cry because someone goes away is that he has an "impression of incompleteness." Rather than truly perceiving those who are there, he feels incomplete when someone goes away. This negative experience does not mean that there is a precise perception of the other *qua* other in the preceding moment. The first external contact with others can be truly given only through extroceptivity. In so far as others are felt only as a kind of state of well-being in the baby's organism because he is held more firmly or more tenderly in their arms, we cannot say that they are actually perceived.

The first active extroceptive stimulus would be the voice. With it begin the reactions that can be called without any possible doubt *definite reactions to others*. At first the human voice as heard by the child provokes only cries when the child is afraid; then, at two months, it provokes smiles. At two or three months one observes that deliberately looking at the child makes him smile. At that moment there will be in the child at least one perception of a look as of something that makes him complete. At the same age the child responds to the cries of other children by calling out himself; there is a kind of contagion of cries that disappears later as the visual perception of others develops. Around that same age, too, the child cries when anyone at all leaves the room and not, as in the beginning, only at the departure of the wet nurse or the person who is feeding him.

At two months and five days one observes, says Wallon, an unmistakably visual experience of another—a recognition of the mother at a distance of two yards. This assumes that the father presents himself in his habitual environment; in an unfamiliar setting, he would not be recognized. At three months the child cries out at all persons who come into his room, even when they are not persons from whom he can expect care.

Concerning relations with other children, here is roughly what happens: I said that at from two to three months there is a contagion of cries among babies and that afterward this contagion disappears, to the extent that visual perception of the other develops. Consequently for a child older than three months the contagion of cries is much rarer than before, and a baby of this age can look with cool detachment at another baby who is crying.

The first beginnings of an observation of others consist in fixations on *the parts of the body*. The child looks at the feet, the mouth, the hands; he does not look at the person. The difference is intuitively quite noticeable between a mere scrutiny of the parts of the body and a look oriented toward the other's look, which seeks to grasp the other as such. The scrutiny of the parts of the other's body considerably enriches the perception that the child can have of his own body. We see him systematically relating to himself, after six months, the different things he has learned about the other's body from looking at him. Still at five months there is no fraternization with children of the same age. At six months, at last, the child looks the other child in the face, and one has the impression that here, for the first time, he is perceiving another.

[3] After Six Months: Consciousness of One's Own Body and the Specular Image

It is now up to us to describe the phase intervening after six months, which will be characterized by a sharp opposition to the first phase. It involves the development of perception of one's own body—a step which is considerably aided by the child's becoming acquainted with the image of his body in the mirror. This is a phenomenon of great importance, since the mirror furnishes the child with a perception of his own body that he could never have got by himself. On the other hand, there is an extraordinarily rapid development of contacts with others—so rapid, in fact, that Wallon was led to speak of and characterize the period between six months and one year as one of "incontinent sociability."

1. *The syncretic system "me-and-other" (after six months)*

At this point we propose to examine simultaneously the development of the experience of one's own body (in its introceptive aspect and in the specular image [13]) and that of the consciousness of the other, beginning at six months.

The major fact that concerns the development of consciousness of one's own body is the acquisition of a representation or a visual image

13. *"L'image spéculaire."* Almost always this term designates the image of himself that is gradually acquired by the child from experiences of his own reflection in the mirror. When Merleau-Ponty refers merely to the physical, episodic event of a body's reflection in a mirror, he uses *"L'image du miroir."* The importance of distinguishing between the image as a physical event and as a development in the life history of the child has led me to translate this term throughout as "specular image," leaving "mirror image" to refer to the former, narrower sense.—*Trans.*

of the body itself, in particular by means of the mirror. The study of this specular image, the recognition of this image and the different stages it passes through are the subjects we shall be concerned with at first.

On this point there is a contrast between the behavior of animals and of children. We cannot say that animals pay no attention to their images in the mirror or that they show no reaction to their specular images. But the conduct of animals is very different from that of children. The first information on the subject was given by Preyer in his now outdated book.[14] The story concerns a duck who, deprived of his mate's company by her death, developed the habit of sitting in front of a windowpane in which his body was reflected. This behavior, according to Wallon [*Les origines du caractère chez l'enfant*], would not be comparable to what one finds in the child. The animal, made incomplete by his mate's death, "completes" himself with his image in the windowpane. He does not take it to be an image of himself, since it is capable of taking the place of another living being; it is like a second animal facing him. Again, inversely, one could say that if in truth the reflected image represents for the animal what was formerly represented by the presence of his mate, the mate was, while he was perceiving her, only a kind of mirror image of himself. In both cases the conduct characteristic of the child (which we shall define shortly) does not yet appear.

Wallon describes the reactions of two dogs to their images in the mirror. One of the dogs displays reactions of fear and avoidance; when he sees his image in the mirror he turns and runs. The other dog, caressed by his master while looking at his image in the mirror, calmly stands still and at the same time turns his head toward his master, who caresses him. The image he sees in the mirror is not, for him, another dog, but neither is it *his own* visual image. The visual image is a kind of complement for him, and as soon as his master's caress recalls him to his body as given in introceptivity, he neglects the mirror image and turns toward the master. Here again, in other words, the animal does not display conduct that is characteristic of the symbol, of the external image as such. In the presence of the mirror he is disoriented, confused, and turns away hastily in order to return to the objects that for him are fundamental—that is, to return to introceptive experience.

The behavior of chimpanzees toward the mirror was studied by Köhler in his fine book, *The Mentality of Apes*.[15] There the author shows that when the chimpanzee is placed in front of a mirror and

14. Merleau-Ponty may be referring to Thierry Wilhelm Preyer, *The Mind of the Child*, trans. H. W. Brown (New York, 1893).—*Trans.*

15. New York, 1925.—*Trans.*

finds an image in it, he passes his hand behind it and shows signs of dissatisfaction at finding nothing behind the image. From then on he stubbornly refuses to interest himself in the mirror. Wallon interprets this as follows: At the moment when—through the manual exploration that could convince him that there was really only a simple image instead of another body—the chimpanzee was about to reach consciousness of the image or treat what is in the mirror as a simple reflection or symbol of his real body, he recoils from the object and treats it as foreign. Consciousness of the image *qua* image scarcely appears, and is only roughly outlined in him. Köhler, however, indicates that the chimpanzee seems to recognize himself in a portrait of himself when presented to him. A repeated experimental study of this phenomenon might well be made in order to see whether in fact chimpanzees are conscious of their portraits and, if so, why they do not achieve a full consciousness of the specular image.

These conducts, we have said, must be contrasted with those of the child. Let us begin by considering not the child's image of his own body in the mirror but instead the image he has of others' bodies. One notices, in effect, that he acquires the latter much more rapidly, that he distinguishes much more quickly between the other's specular image and the reality of the other's body than he does in the case of his own body. Thus it is possible that the experience he has of the other's specular image helps him arrive at an understanding of his own.

According to Guillaume [*l'Imitation chez l'enfant*], the consciousness of the other's image in the mirror comes at an early age. Guillaume observes grimaces before a mirror in the first weeks of life. Wallon thinks, however, that clear reactions to the specular image are not noticeable before the end of the third month.

At first there is a reaction of simple fixation on the specular image (around four or five months). This is followed by reactions of interest in the same image. At the same moment, one notices reactions in the child, e.g., to a portrait by Franz Hals. Finally, after six months, reactions other than the mimic or affective are seen to appear. These are genuine conducts. After five or six months, for example, there occurs the following:

A child smiles in a mirror at the image of his father. At this moment his father speaks to him. The child appears surprised and turns toward the father. As a result it seems that at this moment he *learns* something. What exactly does he learn? He is surprised, because at the moment before his father spoke, he did not have a precise awareness of the relation of image to model. He is surprised that the voice comes from another direction than that of the visible image in the mirror. The attention he gives to the phenomenon shows, in effect,

that he is in the process of understanding something, that it is not a question of simple training. One might be tempted to say that we are here present at the formation of a conditioned reflex and that the mirror image becomes "comprehensible" by becoming the conditioned stimulus of responses that were formerly evoked by the father. In Wallon's eyes there can be no question either of a blind training or of an intellectual mastery of the image. Certainly one cannot say that the child comes into possession of a perfectly clear relation between the image and the model or that he learns to consider the mirror image as a spatial projection of the visible aspect of his father. The experience of which we are speaking occurs at about five or six months and does not give the child possession of a stable conduct. Just as the child studied by Wallon turned away from the specular image toward his father after a week, so several weeks later he still tried to grasp the image in the mirror with his hand; this means that he had not yet identified this image as a "simple image" that was nothing other than visible.

We should say that in this first phase of his apprenticeship, the child gives the image and the model an existence relatively independent of each other. There is the model, which is the father's body, the real father; there is in the mirror a sort of double or phantom of the father, having a "secondary existence" without the image being reduced to the simple state of a reflection of light and color in external space. When the child turns away from the mirror toward his father, we may indeed say that he recognizes his father in the image but in an altogether practical way. He turns toward his father because that is where the voice is coming from; but it cannot be said that at this point he has divested the specular image of its quasi-reality, the phantom existence it first had for him, nor can we try to render it with the aid of certain analogies borrowed from primitive thought. The image thus has an existence inferior to that of the father's real body—but it does have a sort of marginal existence.

Let us now consider the acquisition of the specular image of one's own body. It is around the age of eight months—hence later than in the case of the specular image of the other—that one clearly finds a reaction of surprise when the child sees his own image in the mirror. At thirty-five weeks the child still extends his hand toward his image in the mirror and appears surprised when his hand encounters the surface of the glass. At the same age he happens to look at his image in the glass when he is called. The illusion of reality, the quasi-reality he lends to the image, still remains, just as after several weeks the child still turns away from the specular image and toward his father. This confirms the fact that, if the child has an adaptive reaction, this does not entail that he has acquired a symbolic consciousness of the image.

Why does the specular image of one's own body develop later than that of the other's body? According to Wallon (whose analysis we are following here), it is because the problem to be solved is much more difficult in the case of one's own body. The child is dealing with two visual experiences of his father: the experience he has from looking at him and that which comes from the mirror. Of his own body, on the other hand, the mirror image is his only complete visual evidence. He can easily look at his feet and his hands but not at his body as a whole. Thus for him it is a problem first of understanding that the visual image of his body which he sees over there in the mirror is not himself, since he is not in the mirror but here, where he feels himself; and second, he must understand that, not being located there, in the mirror, but rather where he feels himself introceptively, he can nonetheless be seen by an external witness *at the very place at which he feels himself to be* and with the same visual appearance that he has from the mirror. In short, he must displace the mirror image, bringing it from the apparent or virtual place it occupies in the depth of the mirror back to himself, whom he identifies at a distance with his introceptive body.

Consequently, in the case of the image of his own body, we must admit, says Wallon, that the child begins by seeing the specular image as a sort of double of the real body—much more so indeed than in the case of the image of the other's body.

Many pathological facts bear witness to this kind of external perception of the self, this "autoscopy." First, it is found in many dreams, in which the subject figures as a quasi-visible character. There would also be phenomena of this kind in dying people, in certain hypnotic states, and in drowning people. What reappears in these pathological cases is comparable to the child's original consciousness of his own visible body in the mirror. "Primitive" people are capable of believing that the same person is in several places at the same time. This possibility of *ubiquity*, difficult for us to understand, can be illuminated by the initial forms of the specular image. The child knows well that he is there where his introceptive body is, and yet in the depth of the mirror he sees the same being present, in a bizarre way, in a visible appearance. There is a mode of spatiality in the specular image that is altogether distinct from adult spatiality. In the child, says Wallon, there is a kind of space clinging to the image. All images tend to present themselves in space, including the image of the mirror as well. According to Wallon, this spatiality of adherence will be reduced by intellectual development. We will learn gradually to return the specular image to the introceptive body and, reciprocally, to treat the quasi-locatedness and pre-spatiality of the image as an appearance that counts for nothing against the unique space of real things. Our intelligence would, so to

speak, redistribute the spatial values, and we would learn to consider as relevant to the same place appearances which, on first sight, present themselves in different places. Thus an ideal space would be substituted for the space clinging to the images. It is necessary, in effect, that the new space be ideal, since for the child it is a question of understanding that what seems to be in different places is in fact in the same place. This can occur only in passing to a higher level of spatiality that is no longer the intuitive space in which the images occupy their own place.

This constitution of an ideal space would include all kinds of degrees. First, there would be, as we have just mentioned, the reduction of the image to a simple appearance lacking its own spatiality. This reduction occurs fairly early, at around one year. Guillaume describes an observation made on his own daughter, who steps before a mirror with a straw hat which she has been wearing since the morning. She puts her hand not to the image of the hat in the mirror but to the hat on her head; the image in the mirror suffices to call forth and regulate a movement adapted to the object itself. In this case one can say that the reduction has been accomplished, that the mirror image is no longer anything but a symbol, and that it returns the child's consciousness to the reflected objects in their proper places.

A counterproof: Each time there occur troubles with the symbolic consciousness—as, for example, in cases of aphasia or apraxia—one also finds troubles with spatiality. Apraxic subjects are known in particular for their difficulty in ordering movements adapted to objects by means of a mirror (or in imitating a subject who is facing them). For them the relation of the image to the model is disturbed and confused.

At one year, according to Wallon, one could say that this development is essentially complete. But this does not mean that the system of correspondence between the image of the body and the body itself is complete or that it is precise. This is shown by a whole series of events, certain of which come fairly late. For example, from twelve to fifteen months of age, the child is seen practicing a series of exercises that prepare for the habit of performing movements in front of the mirror. He is trying out the kind of movements that the apraxic is asked to perform. And this occurs after the first year, at between twelve and fifteen months; that is, the system at this moment is still quite fragmentary and the child needs to confirm it by repeated experiments. At sixty weeks (i.e., at more than a year), when the mother is sitting beside the child with a mirror in front of them and the child is asked to point to his mother, the child points to her in the mirror *while laughing* and turns back to her. The specular image has become the subject of a game, an amusement. But the very fact that the child thinks of using

his specular image to play with shows that he is not so far removed from the experiments that first introduced him to the specular image.

The apprenticeship is not yet very stable. At fifty-seven weeks (thus at more than a year) Preyer's son looked at himself in the mirror, passed his hand behind the mirror, brought his hand back, and contemplated it. This, as we have seen, is exactly what chimpanzees do. The next day he turned away from the mirror, just like the chimpanzees. All the same, this fact would appear a bit difficult to admit if, as Guillaume thinks, the consciousness of the specular image has already been acquired at the age of one year. How could one revert after that age to the conduct of chimpanzees, which, as we have seen, is inferior to the level of consciousness of the image? Wallon proposes an explanation: In the case we are considering, he says, it is not so much a misunderstanding of the specular image; it is on the mirror, not on the image, that the inquiry bears. The child would have discovered once for all that what is portrayed over there on the mirror is only an appearance, a reflection, but it remains for him to understand *how* an object (the mirror) is capable of obtaining a duplicate of the surrounding objects. Wallon's interpretation is not entirely convincing. In order for there to be an exact consciousness of the image in its relation to the model, it seems necessary for there to be some understanding of the role of the mirror. In so far as the mirror is not at all understood, to the extent that the child expects to find in back of it something like the objects which outline themselves on its surface, he has not yet fully understood the existence of the reflection; he has not yet fully understood the image. If his consciousness of the image were entirely perfect, the child would no longer search behind the mirror for real objects similar to the ones reflected in it. The constitution of a specular image that would be in the fullest sense a *reflection* of the real object presupposes the gradual constitution of an entire naive physics, into which would enter the causal relations that are designed to explain how the phenomenon of the reflection is possible.

The facts set forth by Preyer thus would seem to show that at fifty-seven weeks there still is no full understanding of the specular image. Hence we will not be astonished that even at sixty-one weeks Preyer's son still touched, licked, struck, and played with his image. Like the game of the child who laughed at his mother's image, this game seems to show that the child is not far from the time when the image was still a double, a phantom of the object. Wallon says that a child of twenty months kisses his image very ceremoniously before going to bed and even at thirty-one months the child is seen to play with his own image.

We have seen that Wallon considers that these games played by the

child with his own image represent a phase beyond the simple consciousness of the specular image. If the child plays with his own image in the mirror, says Wallon, it is because he is amusing himself by finding in the mirror a reflection which has all the appearances of an animated being and yet is not one. Here it would be a question of "animistic games," an activity which proclaims that animistic *beliefs* have been suppressed. But why should it be so amusing somehow to verify the animistic appearance if there remained in the subject no traces of this amazing phenomenon which on first encounter so fascinated the child—namely, the presence of a quasi intention in a reflection? The child happily makes a sort of fairy dance before it and clings to it, although it is not "for real."

This leads us to make a remark which perhaps will have to be recalled in concluding. For adults like ourselves, the mirror image has really become what Wallon would like it to be in an adult mind: a simple reflection. Nonetheless there are two ways in which we can consider the image—one, a reflective, analytic way according to which the image is nothing but an appearance in a visible world and has nothing to do with me; the other, a global and direct one, of the kind which we use in immediate life when we do not reflect and which gives us the image as something which *solicits* our belief. Let us compare the mirror image to a painting. When I look at a painting of Charles XII of Sweden, with his elongated face and that head which, according to his contemporaries, only one idea could enter at a time, I know very well that Charles XII has been dead for a long time and that what I am looking at is no more than a painting. Nonetheless there is a *quasi-person* who is smiling; that line joining nose and lips, that flashing in the eyes are not simply things. This congealed movement is, all the same, a *smile*. In the same way the image in the mirror, even for the adult, when considered in direct unreflective experience, is not simply a physical phenomenon: it is mysteriously inhabited by me; it is something of myself.

This experience allows us to understand the significance attached to images in certain civilizations. There one is forbidden to make images of men because this is similar to deliberately creating other human beings—and this is not man's proper function. This group of beliefs related to images can be understood only if images are more than black-and-white sketches or simple signs of a person who remains absolutely distinct from them. In a singular way the image incarnates and makes appear the person represented in it, as spirits are made to appear at a séance. Even an adult will hesitate to step on an image or photograph; if he does, it will be with aggressive intent. Thus not only is the consciousness of the image slow in developing and subject to

relapses, but even for the adult the image is never a simple reflection of the model; it is, rather, its "quasi-presence" (Sartre).

This also explains why the work of "reduction," even when done by the child in respect to the image in the mirror, never ends with a *general* result, such as a concept. The child must do the work all over again in respect to other analogous phenomena—shadows, for example. Wallon remarks that Preyer's son, at the age of four years, noticed for the first time that he cast a shadow and noticed it with fright. A little girl, four and a half years old, observed by Wallon, pretended that when she stepped on Wallon's shadow she was stepping on Wallon himself. The participationist beliefs with which, as we have said, the specular image is at first endowed have not been reduced by an intellectual critique that would apply indifferently to all phenomena of the same order. The progress consists in a restructuration of the specular image. The child puts this image at a distance, but this distance is not that of the concept.

Wallon would like to say that in the case of the shadow it is a matter of beginning the same development that has already been acquired in the case of the specular image. But this would be to say that the progressive reduction of the specular image is not, properly speaking, an intellectual phenomenon. A genuine intellectual event would obey the "all or nothing" law: either one knows or one does not know. One cannot "slightly know" the sum of two and three. The intellectual phenomenon is not susceptible to that series of gradations that one observes in the development of the specular image.

This leads us to ask whether, in the light of several other facts, there is room to reattempt to interpret the development of the specular image and relate it to phenomena other than those of knowledge.

Wallon's book also contains indications along these lines. Wallon himself, in certain passages in *Les origines du caractère chez l'enfant*, suggests that the progress in experiencing one's own body is a "moment" in a global development that also involves the perception of others.

At the end of his analysis Wallon sharply criticizes the notion of cenesthesia, considered as a series of images given directly and immediately by my organs and bodily functions and representing these organs and functions to me. According to Wallon, this cenesthesia, when it exists, is the result of a very long development; it is a fact of adult psychology and altogether fails to express the relation between the child and his body. The child in no way distinguishes at first between what is furnished by introception and what comes from external perception. There is no distinction between the data of what the learned adult calls introceptivity and the data of sight. The specular

image, given visually, participates globally in the existence of the body itself and leads a "phantom" life in the mirror, which "participates" in the life of the child himself. What is true of his own body, for the child, is also true of the other's body. The child himself feels that he is in the other's body, just as he feels himself to be in his visual image. It is this that Wallon suggests n showing by the examination of pathological cases: *that disorders in "cenesthesia" are closely linked with troubles in my relations with others.*

Sick people feel a voice speaking in the region of the epigastrium, in the throat, the chest, or the head. Classical psychiatrists thought that this must be a question of hallucinations involving different regions of the body. They translated and "put into images" the complaints of the sick, taking quite literally what the patients said.

Modern psychiatry shows, however, that what is essential and primary about the phenomena in question is not the location of voices in the subject's body, but rather a sort of "syncretism" that intervenes in his relations with others and causes alien voices to inhabit his own body. If the patient hears voices in his head, this is because he does not absolutely distinguish himself from others and because, for example, when he speaks, he can just as well believe that someone else is speaking. The patient, says Wallon, has the impression of being "without boundaries" in relation to the other, and this is what makes his acts, his speech, and his thoughts appea to him to belong to others or to be imposed by others.

This interpretation of the so-called cenesthesic disorders is closely connected with the analyses of Daniel Lagache in *Les hallucinations verbales et la parole.*[16] Lagache thinks that the question "How can we understand a subject who believes that he is hearing when it is he who is speaking?" can be answered only if one conceives language to be a kind of "we-operation" [*opération à deux*]. There is a sort of indistinction between the act of speaking and the act of hearing. The word is not understood or even heard unless the subject is ready to pronounce it himself, and, inversely, every subject who speaks carries himself toward the one who is listening. In a dialogue, the participants occupy both poles at once, and it is this that explains why the phenomenon of "speaking" can pass into that of "hearing." It is this primordial unity that reappears in pathological cases.

What this observation reveals when we rid ourselves of sensationalist prejudices, says Wallon, is the "inability to distinguish the active from the passive," myself from the other. Here we come very close to what the psychoanalysts call "projection" and "introjection," since

16. D. Lagache, *Les hallucinations verbales et la parole* (Paris, 1934).

these mechanisms consist, for the subject, in assuming as his own the conduct of another or in attributing to the other a conduct that is really his own.

There is thus a system (my visual body, my introceptive body, the other) which establishes itself in the child, never so completely as in the animal but imperfectly, with gaps. It is founded on the indistinction of the several elements that enter into it, rather than on an ordered relation and a two-way correspondence of its different elements. One may presume that, just as there is a global identification of the child with his visual image in the mirror, so also will there be a global identification of the child with others. If the child under six months of age does not yet have a visual notion of his own body (that is, a notion that locates his body at a certain point in visible space), that is all the more reason why, during this same period, he will not know enough to limit his own life to himself. To the extent that he lacks this visual consciousness of his body, he cannot separate what *he* lives from what *others* live as well as what he sees them living. Thence comes the phenomenon of "transitivism," i.e., the absence of a division between myself and others that is the foundation of syncretic sociability.

These remarks made by Wallon at the end of his book go much further than does his analysis of the specular image, and allow us to correct and complete the latter. Wallon's study of the specular image scarcely characterizes it in a positive way. It shows us how the child learns to consider the mirror image as unreal, to reduce it; hence the disillusionment with which the child deprives the specular image of the quasi-reality he gave it at first. But we must also ask why the specular image *interests* him and what it is for the child to know that *he has a visible image.* Wallon himself says that the child "amuses himself" with his image "to the point of excess."[17] But why is the image so *amusing*?

It is this that the psychoanalysts have tried to understand. Dr. Lacan begins by observing exactly what Wallon noticed: the child's extreme amusement in the presence of his image, his "jubilation" at seeing himself moving in the mirror. The child is not yet walking; he stands sometimes with difficulty. All traces of prenatal life have not yet been effaced in him; all neural connections have not yet matured. He is still far from being adapted to the physical world around him. Is it not surprising, under these conditions, that he takes such a lively, universal, and constant interest in the phenomenon of the mirror? Dr. Lacan's answer is that, when the child looks at himself in the mirror and recognizes his own image there, it is a matter of *identification* (in

17. *Les origines du caractère chez l'enfant*, p. 177.

the psychoanalytic sense of the word)—that is, of "the transformation occasioned in the subject when he assumes." [18] For the child, understanding the specular image consists in *recognizing as his own* this visual appearance in the mirror. Until the moment when the specular image arises, the child's body is a strongly felt but confused reality. To recognize his image in the mirror is for him to learn that *there can be a viewpoint taken on him*. Hitherto he has *never seen himself*, or he has only caught a glimpse of himself in looking out of the corner of his eye at the parts of his body he can see. By means of the image in the mirror he becomes capable of being a spectator of himself. Through the acquisition of the specular image the child notices that he is *visible*, for himself and for others. The passage from the introceptive *me* to the visual *me*, from the introceptive *me* to the "specular I" (as Lacan still says), is the passage from one form or state of personality to another. The personality before the advent of the specular image is what psychoanalysts call, in the adult, the ego (*soi*), i.e., the collection of confusedly felt impulses. The mirror image itself makes possible a contemplation of self. With the specular image appears the possibility of an ideal image of oneself—in psychoanalytic terms, the possibility of a super-ego. And this image would henceforth be either explicitly posited or simply implied by everything I see at each minute.

Thus one sees that the phenomenon of the specular image is given by psychoanalysts the importance it really has in the life of the child. It is the acquisition not only of a new content but of a new function as well: the narcissistic function. Narcissus was the mythical being who, after looking at his image in the water, was drawn as if by vertigo to rejoin his image in the mirror of water. At the same time that the image of oneself makes possible the knowledge of oneself, it makes possible a sort of alienation. I am no longer what I felt myself, immediately, to be; I am that image of myself that is offered by the mirror. To use Dr. Lacan's terms, I am "captured, caught up" by my spatial image. Thereupon I leave the reality of my lived *me* in order to refer myself constantly to the ideal, fictitious, or imaginary *me*, of which the specular image is the first outline. In this sense I am torn from myself, and the image in the mirror prepares me for another still more serious alienation, which will be the alienation by others. For others have only an exterior image of me, which is analogous to the one seen in the mirror. Consequently others will tear me away from my immediate inwardness much more surely than will the mirror. The specular image is the "symbolic matrix," says Lacan, "where the *I*

18. Cf. Jacques Lacan, "Le stade du miroir comme formateur du fonction du Je," *Revue Française de Psychanalyse*, vol. 13 (October–December, 1949), pp. 449–55. Also the same author, "Les effets psychiques du mode imaginaire," *l'Evolution Psychiatrique* (January–March, 1947).

springs up in primordial form before objectifying itself in the dialectic of identification with the other."

The general function of the specular image would be to tear us away from our immediate reality; it would be a "de-realizing" function. The author insists that it is astonishing that such a phenomenon appears in a subject of whom we have said earlier that he is very far from maturity in the biological and motor spheres. The human child is that being who is capable of sensitivity to others and of considering himself one among other similar men long before the true state of physiological maturity. "Pre-maturation" and anticipation are essential phenomena for childhood; childhood makes possible both a development, unknown to animality and an insecurity that is proper to the human child. For inevitably there is conflict between the *me* as I feel myself and the *me* as I see myself or as others see me. The specular image will be, among other things, the first occasion for aggressiveness toward others to manifest itself. That is why it will be assumed by the child both in jubilation and in suffering. The acquisition of a specular image, therefore, bears not only on our *relations of understanding* but also our *relations of being*, with the world and with others.

Thus in this phenomenon of the specular image, so simple at first glance, will be revealed to the child for the first time the possibility of an attitude of self-observation that will develop subsequently in the form of narcissism. For the first time the *me* ceases to confuse itself with what it experiences or desires at each moment. On this immediately lived *me* there is superimposed a constructed *me*, a *me* that is visible at a distance, an imaginary *me*, which the psychoanalysts call the super-ego. Henceforth the child's attention is captured by this "*me* above the *me*" or this "*me* before the *me*." From this moment on, the child also is drawn from his immediate reality; the specular image has a de-realizing function in the sense that it turns the child away from what he effectively is, in order to orient him toward what he sees and imagines himself to be. Finally, this alienation of the immediate *me*, its "confiscation" for the benefit of the *me* that is visible in the mirror, already outlines what will be the "confiscation" of the subject by the others who look at him.

An analysis of this kind extends what we have found in Wallon, while at the same time it is different. It is different mainly because it emphasizes the affective significance of the phenomenon. In reading Wallon one often has the feeling that in acquiring the specular image it is a question of a labor of understanding, of a synthesis of certain visual perceptions with certain introceptive perceptions. For psychoanalysts the visual is not simply one type of sensibility among others; it has an altogether different type of significance for the subject's life

from those of other modes of sensibility. Is vision, the sense of spectacle, also the sense of the imaginary? Our images are predominantly visual, and this is no accident; it is by means of vision that one can sufficiently dominate and control objects. With the visual experience of the self, there is thus the advent of a new mode of relatedness to self. The visual makes possible a kind of schism between the immediate *me* and the *me* that can be seen in the mirror. The sensory functions themselves are thus redefined in proportion to the contribution they can make to the existence of the subject and the structures they can offer for the development of that existence.

In addition, the study of the phenomenon made by the psychoanalysts stresses both the anticipations and the regressions contained in its development.

"Pre-maturation," the anticipation by the child of adult forms of life, is for the psychoanalysts almost the definition of childhood. It is an advance made by the subject beyond his present means. The child always lives "beyond his means"; birth itself is "pre-mature," since the child comes into the world in a state in which independent life in his new environment is impossible for him. The first Oedipal impulse is a "psychological puberty," in contrast to the organic puberty of the individual, and is awakened by his relations with the adult world. The child lives in relations that belong to his future and are not actually realizable by him.

But while the child may anticipate, the adult may regress. Childhood is never radically liquidated; we never completely eliminate the corporeal condition that gives us, in the presence of a mirror, the impression of finding in it something of ourselves. This magic belief, which at first gives the specular image the value not of a simple reflection, of an "image" in the proper sense, but rather of a "double" of oneself—this belief never totally disappears. It re-forms itself in the emotional make-up of the adult. For this reduction to be possible, the "reduction" of the image must be not so much an irreversible progression of the understanding as a restructuration of our entire manner of being continually exposed to the accidents of emotional experience.

If the comprehension of the specular image were solely a matter of cognition, then once the phenomenon was understood its past would be completely reassimilated. Once the purely physical character of the reflection or of the phenomenon of the image was understood, there would remain nothing of the "presence" of the person reflected in his image. Since this is not the case, since the image-reflection is unstable, the operations that constitute it involve not only the intelligence proper but, rather, all the individual's relations with others.

Moreover, what distinguishes the psychoanalysts' remarks concerning the specular image is that they relate the specular image to identification with others. I understand all the more easily that what is in the mirror is my image for being able to represent to myself the other's viewpoint on me; and, inversely, I understand all the more the experience the other can have of me for seeing myself in the mirror in the aspect I offer him.

Wallon, we have said, accounts for the reduction of the specular image in terms of an intellectual operation. I first see in the mirror a double of myself; then an act of intellectual consciousness of my own experience makes me withdraw existence from this image and treat it as a simple symbol, reflection, or expression of the same body that is given in introceptivity. Intellectual activity operates at every moment of these reductions and integrations, and detaches the specular image from its spatial roots, transferring this visual appearance and introceptive experience to an ideal place in a space that is not the spatiality adhering to the sensed but the spatiality constructed out of the intelligence.

It is altogether undeniable that such a reduction occurs. But the question is one of knowing whether the intellectual operation in which it culminates can offer a *psychological explanation* for what takes place. The emergence of an ideal space, the redistribution, by the intelligence, of the spatial values that makes me withdraw from the image its own location in order to treat it as a simple modality of a unique placement of my body—is all this the *cause* or the *result* of the development?

Wallon remarks incidentally that we should not suppose that the child *begins by locating his own body in two places* or that there is a certain place where the tactile, introceptive body is situated and another place for the aspect, or visual appearance, of the body. If this were done, one would be realizing twice over in the child a rigorous form of spatiality that in fact belongs only to the adult. The child at first sees the image "over there" and feels his body "here." This does not mean that when he visually perceives the image and tactually perceives his body, he actually places each one at a distinct point in space in the same sense in which the adult, for example, perceives this microphone and that lamp *as being in two distinct places*. The two "spaces," says Wallon, are not immediately comparable, and any precise intuition of their mutual exteriority would require a sort of common denominator between them which is not immediately given by sense experience. In the case of the specular image, instead of a second body which the child would have and which would be located elsewhere than in his tactile body, there is a kind of *identity at a distance*, a *ubiquity* of the body; the body is at once present in the mirror and present at the point

where I feel it tactually. But if this is the case, the two aspects that are to be co-ordinated are not really separated in the child and are in no way separated in the sense in which all objects in space are separated in adult perception. Since Wallon's analysis rests on the ideas (a) that what is involved is a redistribution of spatial values and the substitution of an ideal space for a perceived space and (b) that, as we know ourselves now, we do not have to overcome an absolute duality of visual image and sensed body, his work must be begun all over again. The reduction to unity is not a cataclysm, if it is true that there is no veritable duplicity or duality between the visual body and the introceptive body in spite of the phenomenon of distance that separates the image in the mirror from the felt body.

If the presence of others were allowed a role in the phenomenon of the specular image, one would have a better idea of the difficulty the child has to overcome. The child's problem is not so much one of understanding that the visual and the tactile images of the body—both located at two points in space—in reality comprise only one, as it is of understanding that the image in the mirror is *his* image, that it is what others see of him, the appearance he presents to other subjects; and the synthesis is less a synthesis of intellection than it is a synthesis of coexistence with others.

In looking at the matters more closely, moreover, we see that the two interpretations are not mutually exclusive. For we must consider the relation with others *not only as one of the contents of our experience but as an actual structure in its own right.* We can admit that what we call "intelligence" is only another name designating an original type of relation with others (the relation of "reciprocity") and that, from the start to the finish of the development, the living relation with others is the support, the vehicle, or the stimulus for what we abstractly call the "intelligence."

Thus understood, the phenomenon will necessarily be fragile and variable, as are our affective relations with others and with the world. The anticipations as well as the regressions are more easily conceived. Lacking this kind of concrete and effective interpretation, we should then have to suppose an intellectual control of our experience that never ceases—an activity which, as Wallon holds, operates at every moment to produce the reductions and the integrations. But we are absolutely unconscious of such an activity; in looking at the image in the mirror we are unaware of judging, of performing an intellectual act. We must thus suppose that there is an unperceived activity in us that constantly reduces perceived space, the space of the image, and succeeds in redistributing spatial values. On the contrary, if we suppose that the conquest of the image is only one aspect in the total continuum

made up of all the lived relations with others and the world, it becomes easier to understand how this continuum, once at work, functions as though autonomously and how at the same time, participating in all the contingencies of our relations with others, it is susceptible to degradations and setbacks.

In our hypothesis it is a question of the acquisition of a certain *state of equilibrium* in our perception which, like any privileged state of equilibrium, tends to maintain itself unsheltered from the intervention of experience. Our interpretation would permit us to understand how the adult state can be distinct from the state of childhood without being immune to relapses into childhood.

2. *Syncretic sociability*

BETWEEN THE AGES of six and twelve months, says Wallon, there occurs an outburst of sociability. Wallon speaks of an "incontinent sociability." From the sixth to the seventh month the child, one notices, abandons the behavior of fixation on others without gestures. While this attitude formerly represented a good half of the child's conduct toward others, its frequency now falls to one quarter. Gestures toward his partners (other children) multiply, as do gestures oriented toward his own body. Movements aimed at the other are now four times as frequent as in the first six months of life. In the same period (between seven and twelve months), there are one third more movements directed toward others than there will be during the entire second year. Thus there is an abrupt forward thrust in relations with others, a sharp increase in the quantity and quality of these relations. The very nature of the child's conduct is modified. For example, it is at about seven months that the child begins to smile when he is looked at (and not merely when he is spoken to). Rarely at this time does the child smile at an animal or when alone. Social sensibility develops in an extraordinary manner, and it is remarkably more advanced than relations with the physical world, which at this time are still quite inadequate.

The general character of these relations with others has been competently described by Charlotte Bühler in her 1927 book, *Sociological and Psychological Studies on the First Year of Life.*[19] Mrs. Bühler observed children who found themselves together in the waiting room of a consultation clinic. She first remarks that before the age of three years, it is extremely rare that children are very interested in other children much younger than themselves, probably because until the

19. Charlotte Bühler, Hildegaard Hetzer, Beatrix Tudor-Hart, *Soziologische und Psychologische Studien über das erste Lebensjahr* (Jena, 1927).

age of three the child does not emerge from his own situation or at least not enough to interest himself in subjects who are in an altogether different situation. This is why relations will be established only among children of relatively close ages, as elsewhere the most ordinary observation shows. Among other children of similar ages a frequent relation is that of the child who parades before another child who looks at him. Often one sees pairs of children, one of whom exhibits himself in his most remarkable activities (playing with this or that latest toy, talking, holding forth) while the other watches. This relation is often at the same time a relation of master and slave. In general this despotism requires a gap of at least three months between the children's ages, with the biggest child usually the master. This is not, however, an absolute rule. There are also cases of active despotism on the part of the smallest. This occurs often when the smallest has been brought up with special attention. When, for example, his approval is always sought, he becomes condescending and immediately adopts an attitude which is complementary to the one taken toward him. As Wallon remarks, there is an automatic logic of affective situations; any attitude taken toward the child immediately provokes in him the complementary attitude. Like all weak persons, he takes a show of excessive interest to be a mark of weakness. What characterizes the relation between the child who shows off and the child who watches him, says Wallon, is that the two children find themselves founded in and by the situation. The child who contemplates is truly identified with the one he is watching; he no longer exists except through his favorite comrade. As for the master, his despotism is naturally founded on the weakness of the slave, but also (and above all) it is founded on the slave's feeling of being a slave. As Wallon observes, what really counts, in order for a despotic relation to be established, is not that one party be stronger or more clever than the other; it is that the other recognize that he is weaker, less clever. What the master seeks, following Hegel's famous description of the relation between master and slave, is recognition [*Anerkennung*] by the slave, the consent of the slave to be a slave. The master is nothing without the humiliation of the slave; he would not feel alive without this abasement of the other. The relation in question, says Wallon, would include a confusion of self with another in the same situation of sentiments. The master exists through the recognition of his lordship by the slave, and the slave himself has no other function than to be there to admire and identify with the master. We have here a state of "combination with the other," as Wallon says, that is the mark of childish affective situations.

Under these conditions the importance of the relation of jealousy for the child is easily understood. In jealousy the couple made up of the

child creating a spectacle and the child admiring him is of concern to the latter: the jealous child would like to be the one being watched. Wallon takes as an example the jealousy of dogs. If one is caressed, the other jumps forward to take his place. The desire to be caressed is not so much a positive desire as the feeling of being *deprived of the caresses* given the other. What is essential to jealousy is this feeling of privation, frustration, or exclusion. This jealousy appears at seven months, according to Guillaume; at nine months, according to Wallon. In any case it appears around the critical period we are speaking of. It is later that this jealousy is expressed in sulking. Sulking is the attitude of the child who renounces what it wanted to be and who consequently accepts the anguish of a repressed action.

One might say that the jealous person sees his existence invaded by the success of the other and feels himself dispossessed by him, and that in this sense jealousy is essentially a confusion between the self and the other. It is the attitude of the one who sees no life for himself other than that of achieving what the other has achieved, who does not define himself by himself but in relation to what others have. According to Wallon, all jealousy, even in the adult, represents a nondifferentiation of that kind between oneself and the other, a positive inexistence of the individual that gets confused with the contrast that exists between others and himself. Thus, says Wallon, we must consider adult jealousy as a regression to the mode of childish jealousy.

In relations of jealousy we often find phenomena of cruelty. The child tries to make the other suffer precisely because he is jealous of him, because everything the other has is stolen from him. In fact, however, cruelty is even more complex. I would not covet, in right and principle, what others have if I did not sympathize with them, if I did not consider others as "other myselves." Cruelty must, then, be understood as a "suffering sympathy" (Wallon). When I hurt the other, therefore, I am hurting myself. Consequently to like to hurt the other is to like to hurt oneself also. Here Wallon reaches the psychoanalytic idea of sado-masochism. "If sadism is a pursuit of the other's suffering, it is, however, a suffering felt to the point of pleasure as well as pain by the person who inflicts it."

It is thus with the jealous person. He likes to make himself suffer. He multiplies his investigations, he seeks information, he forms hypotheses that are always designed to stimulate his anguish or uneasiness. Wallon even indicates that in jealousy there is a sort of complacency that has as its end a heightening of the intensity of sexual passion. Wallon points out that the psychological explanation of certain groups of three people is to be found here. The trio would have no other meaning than to organize permanently an experience of jealousy that

is sought by its initiators as an increase of anxiety and because it intensifies the reactions of aggressiveness and sexuality.

For the child, jealousy represents a stage wherein he participates in a total affective situation and senses the complementary life of his own without yet knowing how to isolate or affirm his own. He thus allows himself to be inwardly dominated by the one who plunders him [*le dépouille*]. Having, all told, nothing of his own, he defines himself entirely in relation to others and by the lack of what the others have. Here again we converge with psychoanalytic thought and its definition of jealousy.

Freud admits that a jealousy which seems to be directed toward one person is in reality directed toward another. A man's jealousy of his wife is the rivalry between that man and that woman in the presence of a third person who is the occasion of the jealousy. This leads us to say that in all jealous conduct there is an element of homosexuality. Wallon takes this kind of view when he admits that the jealous man is the one who lives, as his own, not only his own experiences but those of others as well, when he assumes the attitudes of the other (and, for example, the attitudes toward a third). Our relation with another is also always a relation with the other persons whom that other knows; our feelings toward another are interdependent with his feelings toward a third, and blend with them. Relations between two people are in reality more extensive relations, since they extend across the second person to those with whom the second person is vitally related. Likewise when Wallon writes of jealousy, "This feeling is the feeling of a rivalry in a person who does not know how to react except as a spectator possessed by the action of the rival," he is very close to the psychoanalytic considerations of the attitude of the "voyeur" (of which the voyeur, in the current sense of the term, is merely an extreme case). The jealous person allows himself to be trapped or captured by the other and, inversely, moreover, he would like to trap or capture the other in his turn. In his mind he plays all the roles of the situation he finds himself in and not only his own role, of which he has no separate notion.

These analyses also remind us of Proust. As a child, Proust begins to love Gilberte one day when he has been taken out to play in the Champs-Elysées and sees before him the group of children to which Gilberte, but not himself, belongs. His feeling of love is at first the feeling of being excluded. It is not so much that he finds Gilberte lovable as it is that he feels himself outside the group of children.

One is also reminded of the famous analysis of the narrator's jealousy toward Albertine. He cannot tolerate the fact that something of Albertine escapes him completely—for example, her past before he met her. The sole fact that she has a past suffices to make him suffer, and this suffering almost confuses itself with his love. When she is not there he no longer feels anything for Albertine and even believes that he no longer loves her; he can only love her without suffering when she is inanimate in sleep (or, later, when she has disappeared in death). But even at this moment his love consists in *contemplating* her in sleep; that is to say, it remains under the law of jealousy, which is identification of oneself with a seen spectacle.

The negative attitudes of jealousy and cruelty are not the child's only attitudes, although they are quite frequent. There are also attitudes of sympathy. Sympathy must, in Wallon's eyes, be understood to be a primordial and irreducible phenomenon. It appears in the child on a foundation of mimesis, at the moment when, all the same, consciousness of self and consciousness of others begin to be distinguished from one another. Mimesis is the ensnaring of me by the other, the invasion of me by the other; it is that attitude whereby I assume the gestures, the conducts, the favorite words, the ways of doing things of those whom I confront. Wallon shows great insight in relating mimesis to the postural function that allows me to govern my body. It is a manifestation of a unique system which unites my body, the other's body, and the other himself. Mimesis, or mimicry, is the power of assuming conducts or facial expressions as my own; this power is given to me with the power I have over my own body. It is the "postural function appropriate to the needs of expression" (Wallon). The constant regulation of bodily equilibrium, without which no function (and in particular no perceptual function) would be possible in the child, is not merely the capacity to reunite the minimal conditions for balancing the body but is more generally the power I have to realize with my body gestures that are analogous to those I see. Wallon speaks of a kind of "postural impregnation" that is resolved into gestures of imitation. He cites the example of a child who is observed watching a chirping bird for a long time and who, after this "postural impregnation," sets himself to reproducing the bird's sounds as well as something of the bird's bearing. Not only the perception of another child but even that of an animal quite different from the child himself shows up, thanks to the postural function, in attitudes which resemble those of the other and have their same expressive value. In sum, our perceptions arouse in us a reorganization of motor conduct, without our already having learned the gestures in question. We know the famous example of the spectators at a football game who make the proper gesture at the moment when the player would make it. Authors like Guillaume have tried to explain this phenomenon in terms of the awakening of the memory of gestures already made. On such accounts we would substitute ourselves for the

other in thought; we would perform, on our own, acts we already knew how to perform. In fact, however, phenomena of this kind are documented facts, certified even in the case of acts that have never been executed—as, for example, in the case of the child just mentioned who imitates a bird. In Wallon's eyes there is, as a result, a necessity for acknowledging that the body has a capacity for "meditation," for the "inward formulation" of gestures. I see unfolding the different phases of the process, and this perception is of such a nature as to arouse in me the preparation of a motor activity related to it. It is this fundamental correspondence between perception and motility—the power of perception to organize a motor conduct that Gestalt theorists have insisted on—that allows the perception of fear to translate itself into an original motor organization. This is what would be the function of mimesis, or mimicry, in its most fundamental and irreducible form.

Sympathy would emerge from this. Sympathy does not presuppose a genuine distinction between self-consciousness and consciousness of the other but rather the absence of a distinction between the self and the other. It is the simple fact that I live in the facial expressions of the other, as I feel him living in mine. It is a manifestation of what we have called, in other terms, the system "me-and-other."

Before passing to the crisis at three years, let us try to shed light from another viewpoint on what we were able to say about the period from six months to three years, by insisting on two points: first, on the conception of the personality that seems to be immanent in this phase of childhood development and, finally on the expression which the phenomenon of pre-communication finds in the language of the child.

In the period of pre-communication, of which we spoke earlier, the personality is somehow immersed in the situation and is a function of the child himself or the other beings with whom he lives. A frequent example is that of children who fully recognize their father only on condition that he is found in his customary setting. A child said, for example, that his real father was in Vienna and that the father on vacation with him in the country was not his real father.

But the child confuses himself with his situation. One recalls the example of a child who had a glass in his hand (against his father's wishes), put it down and, on hearing the sound of breaking glass five minutes later, started and became just as agitated as if he still had the glass in his hand. He created a sort of magic link between the forbidden thing he had done several minutes earlier and the breaking of the glass, far away from him. In a case like this one, there is in the child no distinct conception of moments of time, nor is there any distinct conception of causal relations. The child confuses himself with his situation. He is someone who has been holding a glass in his hand, someone

who has had a relation with the glass, so that the subsequent breaking of the glass concerns him.

Elsa Köhler, in her book on the personality of the three-year-old,[20] tells the story of a child who had eaten her brother's candy while her brother and parents were away. The moment the father returned, the little girl ran up to him, telling him enthusiastically how much fun she had had eating her brother's candy and trying to make him share her pleasure. The father reprimanded her; the little girl cried and appeared convinced that she had done something wrong. A short time later the mother appeared, and *the same scene was repeated.* How are we to explain this? At bottom it is the problem of children who, as their parents say, "go right back and do it again." In order to understand why—immediately following a scene of repentance, tears, and good resolutions—the child repeats exactly the same offense, it is necessary to think that she establishes no connection between the arrival of her mother and that of her father; the two events must be absolutely distinct in her eyes. The child *is*, in fact, the situation and has no distance from it. The situation is taken in its most immediate meaning, and all that happened before is nothing, canceled from the time when a new situation—the mother's return—arises. This incapacity to distinguish between different situations, to adopt a conduct that is autonomous in its relation to the situations and constant in relation to the variable conditions, is what makes the child's attitude understandable. The child was really not the same when she underwent her father's reproaches, deferred to them, and made good resolutions as when her mother returned several minutes later.

William Stern tells of how his son, at the birth of a younger sister, suddenly identified himself with his elder sister, pretended to have her name, and gave her another name. This seems to show that the child identifies himself absolutely with his family situation; and from the birth of the new child, which makes the youngest into a relatively older child, he takes over absolutely the role of the eldest, even to the point of usurping the place of the rightful eldest.

Hence, perhaps, the possibility of understanding how the child can feel himself to be several persons and can simultaneously play several roles—resembling the ill in this respect. Wallon mentions the case of a patient of Janet who declared that she was at the same time both the daughter of the Virgin and the Virgin herself and who showed this, in effect, by all her mimicry, playing the roles of both the expectant mother and the child.

Hence also the real meaning of the child's dialogues with himself. When the child chats with himself (a familiar occurrence to anyone

20. Elsa Köhler, *Die Persönlichkeit des dreijährigen Kindes* (Leipzig, 1916).

who has raised children), there is an actual plurality of roles; one role converses with another.

Finally, we are in a position to understand the frequent phenomena of what is called "transitivism" in the sick and also in the child. Transitivism consists in attributing to others what belongs to the subject himself. For example, a patient will pity another patient for having had a crisis which, in fact, he himself underwent during the night—as though it were the other who had suffered the crisis. Transitivism is also the attitude of hypochondriacs who look for signs of ill health in the faces of others. All that we are, all that happens to us can furnish us with explanatory categories and in every case plays the role of exploratory tools for knowing the other. Everything that happens to us makes us sensitive to a certain aspect of the other and makes us seek in the other the equivalent of, or something that corresponds to, what has happened to us. This is why Goethe was right in saying that for each of us our circle of friends is what we ourselves are. Our *Umwelt* is what we are, because what happens to us does not happen only to us but to our entire vision of the world. Transitivism is, in other words, the same notion that psychoanalysts are using when they speak of *projection*, just as mimesis is the equivalent of *introjection*.

There are striking examples of transitivism in children, too. Wallon mentions one of them, borrowed from the work of Charlotte Bühler. It is the case of a little girl who, when seated beside her maid and another little girl, seemed uneasy and unexpectedly slapped her companion. When asked why, she answered that it was her companion who was naughty and who hit her. The child's air of sincerity ruled out any deliberate ruse. We have here a manifestly aggressive child who gives an unprovoked slap and explains herself right afterward by saying that it is the other child who slapped her. Psychoanalysts have stressed the childlike attitude that consists in imputing the wrong to the other ("*You're* the one who's lying!"). The child who seemed uneasy was passing through a phase of anxiety, and this anxiety impregnated her entire view of things and people around her—in particular her view of the little girl sitting beside her. This little girl appeared to her to be surrounded by the same anguishing aura. The child was living her anxiety, and the gestures appropriate to lessening it, not as interior events but as qualities of things in the world and of others. In the absence of a reduction of the anxiety to its subjective source and a concentration of the anxiety within the child in whom it was actually located, the anxiety was lived as something that has an external as well as an internal origin. Slapping her companion was the little girl's response to the aggression of the anxiety that came from outside.

The child's own personality is at the same time the personality of

the other, that indistinction of the two personalities that makes transitivism possible; this presupposes an entire structure in the child's consciousness. The guilty act of taking the glass, that has just occurred, and the breaking of the glass are now joined in a quasi-magic way. Similarly there is a sort of spatial syncretism—i.e., a presence of the same psychic being in several spatial points, a presence of me in the other and the other in me. In a general way there is an inability to conceive space and time as environments that contain a series of perspectives which are absolutely distinct from one another. The child switches from perspective to perspective, erasing them in the identity of the thing, unaware even of the different profiles or different perspectives in which space can present itself. It is an aspect of the same structure of consciousness that expresses itself in certain childish persons we studied last year [*rabattement*]. The reduction of external perception to what can be seen from a single point of view—in short, the perspective given—is possible only much later. There is also an indistinction between the symbol and what it symbolizes. Words and things are not absolutely distinguished; of this we have already had more than one reminder.

The absence of what we call in the adult the symbolic consciousness, the fusion of sign and referent [*signifié*], the different moments of time and of space in the thing are so many evidences of the same fact.

The syncretic relations with others that show up in the child's conception of personality also show up clearly in the child's use of language. The child's first words, considered by the psychologists and the linguists as standing for sentences (word-sentences), can be the equivalent of entire sentences only through the effects of syncretism. The first word-sentences, as we have already seen, aim just as much at the actions of others as at one's own actions or conducts. When the child (even the very young child) says "hand" (hand-hand), this means his father's hand as well as the hand represented by a photograph or his own hand. This seems to presuppose a kind of abstraction, a recognition of the same object in a plurality of cases. And in fact the object identified is greatly different (for example, there is not a great resemblance between a child's hand and the photograph of an adult's hand). In reality, however, there is no abstraction here. There is simply no radical distinction in the child between his own hand and that of another. The child's extraordinary facility in recognizing the parts of the body in a drawing or an even rougher sketch, the promptness and skill with which he identifies parts of his own body in the bodies of animals that scarcely resemble the human body or familiar domestic animals, the plasticity of vision that allows him to recognize homolo-

gous structures of the body in quite different organisms—all this can be explained by the state of neutral indistinction between self and other in which he lives. The child's own body is for him a way of understanding other bodies through "postural impregnation" (Wallon). The child's person, says Wallon, is in a way scattered through all the images his action gives rise to, and it is because of this that he is apt to recognize himself in everything.

This explains the relative ease with which children understand the modern way of painting and drawing. It is altogether startling to see certain children much more apt to understand this drawing or that painting by Picasso than the adults around them. The adult hesitates before this kind of drawing because his cultural formation has trained him to take as canonical the perspective inherited from the Italian Renaissance, a perspective that works by projection of different external data on a single plane. To the extent that the child is a stranger to this cultural tradition and has not yet received the training that will integrate him within it, he recognizes with great freedom in a number of traits what the painter meant to show. If you like, the child's thought processes are general from the start and at the same time are very individual. They are expressive thought processes that get to the essentials by means of a concrete corporeal recovery [*reprise*] of objects and conducts as given.

This allows us to understand why the use of the word *I* comes relatively late to the child. He will use it when he has become conscious of his own proper perspective, distinct from those of others, and when he has distinguished all of the perspectives from the external object. In the initial state of perception there is consciousness not of being enclosed in a perspective and of guessing—picking out across it an object which is outside—but of being in direct touch with things across a personal-universal vision. The *I* arises when the child understands that every *you* that is addressed to him is for him an *I;* that is, that there must be a consciousness of the reciprocity of points of view in order that the word *I* may be used.

Guillaume points out that in the early months of the second year the child is first seen to acquire a large number of names of persons. Finally, around the sixteenth month, he acquires his own name, which at first he uses only in very limited cases, i.e., in answering questions like "What is your name?" or to designate the situations in which he is placed along with other children—for example, in the distribution of gifts. In this case the child can employ his own name because of the collective operation in which he is involved just like one of the others. The use of his own name in these circumstances does not indicate that he is conscious of his privileged perspective, which seems to escape

him completely at sixteen months or thereabouts. For example, when he wants to say "I want to write," he uses the infinitive, without a subject. Guillaume's son said "write" for "I want to write," but he said "Papa write"; that is, he used the subject only when the subject was another person. When it was he himself who was involved, he never expressed the subject at all. And the "Paul writes" that he finally came to say grew somehow within the formula "Papa writes." The use of his own name was learned from the use of other people's names.

Use of the pronoun *I* comes still later than use of the proper name, at least as it is understood in its full meaning, i.e., in its relative meaning. The pronoun *I* has its full meaning only when the child uses it not as an individual sign to designate his own person—a sign that would be assigned once for all to himself and to nobody else—but when he understands that each person he sees can in turn say *I* and that each person is an *I* for himself and a *you* for others. It is when he understands that even though others call him *you* he can nonetheless say *I*, that the pronoun *I* is acquired in all its significance. Thus it is not because a child of around nineteen months finds he has used the sound "I" that we say that he has acquired the use of the pronoun. In order for it to have been a real acquisition, he must have grasped the relations between the different pronouns and the passage from one of their designata to the others. In other cases the sound "I" is used mechanically, like the body [*physique*], but it is not used in its fullest linguistic and grammatical meaning. Only at nineteen months did Guillaume's son use *me* or *I* in their fullest senses. At nineteen months he used *mine* and *yours* in a systematic way; at twenty months he used *mine, yours, his, everybody's*.[21] At this moment the operation of distribution is conceived in the same way whether it is addressed to the child or to others. The use of *I* takes the place of the child's first name and occurs regularly only at the end of the second year. While the name is an attribute of the person alone, the pronoun designates either the speaker or the person he is speaking to. The same pronoun can serve to designate different persons, while each person has only one proper name.

3. *The "crisis at three years"*

THIS CRISIS HAS BEEN well described by Elsa Köhler in her book on the personality of the three-year-old as well as by Wallon in *Les origines du caractère chez l'enfant.*

At around three years the child stops lending his body and even his thoughts to others, as we have seen happen in the phase of syncretic

21. *"A moi," "à toi," "à lui," "à chacun."*

sociability. He stops confusing himself with the situation or the role in which he may find himself engaged. He adopts a proper perspective or viewpoint of his own—or rather he understands that, whatever the diversity of situations or roles, he is *someone* above and beyond these different situations and roles.

The acquisition of perspective in drawing (which will occur later) can serve us here as a symbol; it will only be possible for a subject to whom the notion of an individual *perspective* is a familiar one. The child cannot understand what it is to portray the things before him as one sees them from a single viewpoint, unless he has come to the idea that he sees them from a single point instead of living in them. There must thus be a kind of duplication of the immediately given sensory spectacle in which the child was at first engulfed and of a subject who is henceforth capable of re-ordering and re-distributing his experience in accordance with the directions chosen by this thought processes. Wallon indicates a certain number of typical attitudes by which one can disclose the advent of this distance between the child on the one hand and the spectacle of others and the world on the other. It is at around the age of three years that one sees in the child the deliberate decision to do everything all alone. Wallon also shows the change in the child's reactions to the look of the other. Up to the age of three years, in general, except in pathological cases, the other's look encourages the child or helps him. Beginning at three years a whole quite different set of reactions is seen to arise; they bring to mind certain pathological reactions. The other's look becomes an annoyance for the child, and everything happens as though, when he is looked at, his attention is displaced from the task he is carrying out to a representation of himself in the process of carrying it out.

This is related to certain pathological phenomena.[22] Wallon mentions the case of a hemiplegic described by Davidson, in whom a convulsive laugh broke out, shaking him all over, whenever he was looked at. Wallon also mentions the case of a subject whose job was testing automobiles. When alone the subject drove skillfully at ninety miles an hour, but when he had a passenger he was tormented by irrepressible tics. This extreme sensitivity to the other's look had shown up very early in this subject—after convulsions at the age of two and a half years. Wallon again recalls the case of general paralytics who, when looked at, show questioning, approving, or satisfied expressions, as though it were absolutely necessary that their faces show something, as though the other's look demanded these expressions of them.

Some subjects who are perfectly normal are afraid of seeming insignificant when being photographed. We can also mention idiots who howl when anyone looks at them. If the three-year-old child is inhibited by the other's look, it is because from this point on he is not simply what he is in his own eyes; he feels himself also to be that which others see him to be. The phenomenon of the specular image, mentioned earlier, becomes generalized. The specular image teaches the child that he is not only what he believed he was by inner experience but that he is in addition that figure he sees in the mirror. The other's look tells me, as does the image in the mirror, that I am *also* that being who is limited to a point in space, that I am that visible "stand-in" [*doublure*] in whom I would recognize only with difficulty the lived *me*. To be sure, as we have seen, this *me* scarcely distinguishes itself from the other before the age of three years. But for this very reason there was never any question of being controlled or inhibited by others; and when this phenomenon appears, it is because the indistinction of myself and the other is at an end.

The ego, the *I*, cannot truly emerge at the age of three years without doubling itself with an *ego in the eyes of the other*. In the case of this phenomenon it is not a question of shame, in the sense in which it exists later on as the shame of being naked (which appears only around the age of five or six), any more than it is the fear of being reprimanded. It is simply a question of the fear experienced by the child when he is looked at.

At the same age the child wants attention and will go to the point of misbehaving in order to get it. Conducts of duplicity that until now were absent are seen to emerge at this time. The child interferes with the play of others for the sake of his own pleasure. He also changes his attitude toward giving. When he gives an object away, he often does it while saying that he does not like the object any more. A thoughtless gift, given earlier, disappears. The child takes things away from others solely for the fun of it; as soon as he has taken them he abandons them. The gift is transformed in the transaction.

In sum, the child constantly calls into play the relation of "me-and-other," which as a result ceases to be a unity, an undifferentiated system, as it is in the preceding phase.

These remarks lead us to ask ourselves to what extent the crisis at three years brings about a transformation and a total re-structuration in the child and whether the state of undifferentiation, of pre-communication, of which we have been speaking until now, is visibly abolished. Wallon himself writes that the already surpassed forms of activity are not abolished. Syncretic sociability is perhaps not liquidated in the third-year crisis. This state of indistinction from others, this mutual impingement of the other and myself at the heart of a situation

22. Cf. Henri Wallon, "La maladresse," *Journal de Psychologie Normale*, vol. 25 (1928), pp. 61–78.

in which we are confused, this presence of the same subject in several roles—all are met with again in adult life. The crisis at three years pushes syncretism farther away rather than suppressing it altogether. Certainly after three years a neutral or objective ground is set up between me and the other; a "lived distance" divides us, as Minkowski says. There is no longer that dizzying proximity of others which made possible certain disorders, certain hallucinations, as well as transitivism.

The child understands, for example, that there is a way of accusing the other that amounts to a confession. Unlike the child, an adult will no longer say, "*You're* the one who's lying." The adult understands that certain resentments disclose in the person expressing them precisely the faults for which he reproaches another. He must be capable of certain meannesses in order to suspect others of them. The adult is conscious of transitivism and the projections whereby we lend others our own ways of being. But if transitivism is thus pushed out of a whole sector of his life, does this mean that it has completely disappeared? The indistinction between me and the other does not inevitably reappear except in certain situations that for the adult are limiting situations but are quite important in his life.

Could one conceive of a love that would not be an encroachment on the freedom of the other? If a person wanted in no way to exert an influence on the person he loved and consequently refrained from choosing on her behalf or advising her or influencing her in any way, he would act on her precisely by that abstention, and would incline her all the more strongly toward choosing in such a way as to please him. This apparent detachment, this will to remain without responsibility arouses in the other an even more lively desire to come closer. There is a paradox in accepting love from a person without wanting to have any influence on her freedom. If one loves, one finds one's freedom precisely in the act of loving, and not in a vain autonomy. To consent to love or be loved is to consent also to influence someone else, to decide to a certain extent on behalf of the other. To love is inevitably to enter into an undivided situation with another.

From the moment when one is joined with someone else, one suffers from her suffering. If physical pain is involved, in which one can participate only metaphorically, one strongly feels his inadequacy. One is not what he would be without that love; the perspectives remain separate—and yet they overlap. One can no longer say "This is mine, this is yours"; the roles cannot be absolutely separated. And to be joined with someone else is, in the end, to live her life, at least in intention. To the very extent that it is convincing and genuine, the experience of the other is necessarily an alienating one, in the sense

that it tears me away from my lone self and creates instead a mixture of myself and the other.

As Alain has said, to love someone is to swear and affirm more than one knows about what the other will be. In a certain measure, it is to relinquish one's freedom of judgment. The experience of the other does not leave us at rest within ourselves, and this is why it can always be the occasion for doubt. If I like, I can always be strict and put in doubt the reality of the other's feelings toward me; this is because such feelings are never *absolutely* proved. This person who professes to love does not give every instant of her life to her beloved, and her love may even die out if it is constrained. Certain subjects react to this evidence as though it were a refutation of love and refuse to be trusting and believe in an unlimited affirmation of the basis of an always-finite number of professions.[23] The ensnaring love of the child is the love that never has enough proofs, and ends by imprisoning and trapping the other in its immediacy.

The normal, non-pathological attitude consists in having confidence above and beyond what can be proved, in resolutely skirting these doubts that can be raised about the reality of the other's sentiments, by means of the generosity of the *praxis*, by means of an action that proves itself in being carried out.

But if these matters are as we have depicted them, all relations with others, if deep enough, bring about a state of insecurity, since the doubt we mentioned always remains possible and since love itself creates its own proper truth and reality. The state of union with another, the dispossession of me by the other, are thus not suppressed by the child's arrival at the age of three years. They remain in other zones of adult life. This is a particular case of what Piaget has called *displacement* [*décalage*]. The same conduct, overcome at a certain level, is not yet (and perhaps will never be) overcome at a higher level. Transitivism, which has been surpassed in the realm of immediate daily life, is never surpassed in the realm of feelings. That is why, as the psychoanalysts have shown, syncretic sociability can be found in the sick to the extent to which they regress in the direction of the conduct of children and show themselves incapable of making the transition to *praxis*, to the selfless, outgoing attitude of the adult.

We might ask what kind of relationship must be established between the crisis at three years mentioned by Wallon and the Oedipal phase of development which certain psychoanalysts locate at the same moment and which accompanies the emergence of the super-ego, the true "objective" relation, and the surpassing of narcissism.

23. The word *abandonniques* appears in the text at this point without explanation.—*Trans.*

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The Need for a New Medical Model: A Challenge for Biomedicine

George L. Engel

At a recent conference on psychiatric education, many psychiatrists seemed to be saying to medicine, "Please take us back and we will never again deviate from the 'medical model.' " For, as one critical psychiatrist put it, "Psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought,' mixed metaphors, role diffusion, propaganda, and politicking for 'mental health' and other esoteric goals" (*1*). In contrast, the rest of medicine appears neat and tidy. It has a firm base in the biological sciences, enormous technologic resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments. It would seem that psychiatry would do well to emulate its sister medical disciplines by finally embracing once and for all the medical model of disease.

But I do not accept such a premise. Rather, I contend that all medicine is in crisis and, further, that medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry. The importance of how physicians conceptualize disease derives from how such concepts determine what are considered the proper boundaries of professional responsibility and how they influence attitudes toward and behavior with patients. Psychiatry's crisis revolves around the question of whether the categories of human distress with which it is concerned are properly considered "disease" as currently conceptualized and whether exercise of the traditional authority of the physician is appropriate for their helping functions. Medicine's crisis stems from the logical inference that since "disease" is defined in terms of somatic parameters, physicians need not be concerned with psychosocial issues which lie outside medicine's responsibility and authority. At a recent Rockefeller Foundation seminar on the concept of health, one authority urged that medicine "concentrate on the 'real' diseases and not get lost in the psychosociological underbrush. The physician should not be saddled with problems that have arisen from the abdication of the theologian and the philosopher." Another participant called for "a disentanglement of the organic elements of disease from the psychosocial elements of human malfunction," arguing that medicine should deal with the former only (*2*).

The Two Positions

Psychiatrists have responded to their crisis by embracing two ostensibly opposite positions. One would simply exclude psychiatry from the field of medicine, while the other would adhere strictly to the "medical model" and limit psychiatry's field to behavioral disorders consequent to brain dysfunction. The first is exemplified in the writings of Szasz and others who advance the position that "mental illness is a myth" since it does not conform with the accepted concept of disease (*3*). Supporters of this position advocate the removal of the functions now performed by psychiatry from the conceptual and professional jurisdiction of medicine and their reallocation to a new discipline based on behavioral science. Henceforth medicine would be responsible for the treatment and cure of disease, while the new discipline would be concerned with the reeducation of people with "problems of living." Implicit in this argument is the premise that while the medical model constitutes a sound framework within which to understand and treat disease, it is not relevant to the behavioral and psychological problems classically deemed the domain of psychiatry. Disorders directly ascribable to brain disorder would be taken care of by neurologists, while psychiatry as such would disappear as a medical discipline.

The contrasting posture of strict adherence to the medical model is caricatured in Ludwig's view of the psychiatrist as physician (*1*). According to Ludwig, the medical model premises "that sufficient deviation from normal represents *disease*, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement in individual patients" (Ludwig's italics). While acknowledging that most psychiatric diagnoses have a lower level of confirmation than most medical diagnoses, he adds that they are not "qualitatively different provided that mental disease is assumed to arise largely from 'natural' rather than metapsychological, interpersonal or societal causes." "Natural" is defined as "biological brain dysfunctions, either biochemical or neurophysiological in nature." On the other hand, "disorders such as problems of living, social adjustment reactions, character disorders, dependency syndromes, existential depressions, and various social deviancy conditions [would] be excluded from the concept of mental illness since these disorders arise in individuals with presumably intact neurophysiological functioning and are produced primarily by psychosocial variables." Such "nonpsychiatric disorders" are not properly the concern of the physician-psychiatrist and are more appropriately handled by nonmedical professionals.

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In sum, psychiatry struggles to clarify its status within the mainstream of medicine, if indeed it belongs in medicine at all. The criterion by which this question is supposed to be resolved rests on the degree to which the field of activity of psychiatry is deemed congruent with the existing medical model of disease. But crucial to this problem is another, that of whether the contemporary model is, in fact, any longer adequate for medicine, much less for psychiatry. For if it is not, then perhaps the crisis of psychiatry is part and parcel of a larger crisis that has its roots in the model itself. Should that be the case, then it would be imprudent for psychiatry prematurely to abandon its models in favor of one that may also be flawed.

The Biomedical Model

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic. Here the reductionistic primary principle is physicalistic; that is, it assumes that the language of chemistry and physics will ultimately suffice to explain biological phenomena. From the reductionist viewpoint, the only conceptual tools available to characterize and experimental tools to study biological systems are physical in nature (*4*).

The biomedical model was devised by medical scientists for the study of disease. As such it was a scientific model; that is, it involved a shared set of assumptions and rules of conduct based on the scientific method and constituted a blueprint for research. Not all models are scientific. Indeed, broadly defined, a model is nothing more than a belief system utilized to explain natural phenomena, to make sense out of what is puzzling or disturbing. The more socially disruptive or individually upsetting the phenomenon, the more pressing the need of humans to devise explanatory systems. Such efforts at explanation constitute devices for social adaptation. Disease par excellence exemplifies a category of natural phenomena urgently demanding explanation (*5*). As Fabrega has pointed out, "disease" in its generic sense is a linguistic term used to refer to a certain class of phenomena that members of all social groups, at all times in the history of man, have been exposed to. "When people of various intellectual and cultural persuasions use terms analogous to 'disease,' they have in mind, among other things, that the phenomena in question involve a person-centered, harmful, and undesirable deviation or discontinuity . . . associated with impairment or discomfort" (*5*). Since the condition is not desired it gives rise to a need for corrective actions. The latter involve beliefs and explanations about disease as well as rules of conduct to rationalize treatment actions. These constitute socially adaptive devices to resolve, for the individual as well as for the society in which the sick person lives, the crises and uncertainties surrounding disease (*6*).

Such culturally derived belief systems about disease also constitute models, but they are not scientific models. These may be referred to as popular or folk models. As efforts at social adaptation, they contrast with scientific models, which are primarily designed to promote scientific investigation. The historical fact we have to face is that in modern Western society biomedicine not only has provided a basis for the scientific study of disease, it has also become our own culturally specific perspective about disease, that is, our folk model. Indeed the biomedical model is now the dominant folk model of disease in the Western world (*5*, *6*).

In our culture the attitudes and belief systems of physicians are molded by this model long before they embark on their professional education, which in turn reinforces it without necessarily clarifying how its use for social adaptation contrasts with its use for scientific research. The biomedical model has thus become a cultural imperative, its limitations easily overlooked. In brief, it has now acquired the status of *dogma*. In science, a model is revised or abandoned when it fails to account adequately for all the data. A dogma, on the other hand, requires that discrepant data be forced to fit the model or be excluded. Biomedical dogma requires that all disease, including "mental" disease, be conceptualized in terms of derangement of underlying physical mechanisms. This permits only two alternatives whereby behavior and disease can be reconciled: the *reductionist*, which says that all behavioral phenomena of disease must be conceptualized in terms of physicochemical principles; and the *exclusionist*, which says that whatever is not capable of being so explained must be excluded from the category of disease. The reductionists concede that some disturbances in behavior belong in the spectrum of disease. They categorize these as mental diseases and designate psychiatry as the relevant medical discipline. The exclusionists regard mental illness as a myth and would eliminate psychiatry from medicine. Among physicians and psychiatrists today the reductionists are the true believers, the exclusionists are the apostates, while both condemn as heretics those who dare to question the ultimate truth of the biomedical model and advocate a more useful model.

Historical Origins of the Reductionistic Biomedical Model

In considering the requirements for a more inclusive scientific medical model for the study of disease, an ethnomedical perspective is helpful (*6*). In all societies, ancient and modern, preliterate and literate, the major criteria for identification of disease have always been behavioral, psychological, and social in nature. Classically, the onset of disease is marked by changes in physical appearance that frighten, puzzle, or awe, and by alterations in functioning, in feelings, in performance, in behavior, or in relationships that are experienced or perceived as threatening, harmful, unpleasant, deviant, undesirable, or unwanted. Reported verbally or demonstrated by the sufferer or by a witness, these constitute the primary data upon which are based first-order judgments as to whether or not a person is sick (*7*). To such disturbing behavior and reports all societies typically respond by designating individuals and evolving social institutions whose primary function is to evaluate, interpret, and provide corrective measures (*5*, *6*). Medicine as an institution and as a discipline, and physicians as professionals, evolved as one form of response to such social needs. In the course of history, medicine became scientific as physicians and other scientists developed a taxonomy and applied scientific methods to the understanding, treatment, and prevention of disturbances which the public

first had designated as "disease" or "sickness."

Why did the reductionistic, dualistic biomedical model evolve in the West? Rasmussen identifies one source in the concession of established Christian orthodoxy to permit dissection of the human body some five centuries ago (*8*). Such a concession was in keeping with the Christian view of the body as a weak and imperfect vessel for the transfer of the soul from this world to the next. Not surprisingly, the Church's permission to study the human body included a tacit interdiction against corresponding scientific investigation of man's mind and behavior. For in the eyes of the Church these had more to do with religion and the soul and hence properly remained its domain. This compact may be considered largely responsible for the anatomical and structural base upon which scientific Western medicine eventually was to be built. For at the same time, the basic principle of the science of the day, as enunciated by Galileo, Newton, and Descartes, was analytical, meaning that phenomena to be investigated be resolved into isolable causal chains or units, from which it was assumed that the whole could be understood, both materially and conceptually, by reconstituting the parts. With mind-body dualism firmly established under the imprimatur of the Church, classical science readily fostered the notion of the body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor's task as repair of the machine. Thus, the scientific approach to disease began by focusing in a fractional-analytic way on biological (somatic) processes and ignoring the behavioral and psychosocial. This was so even though in practice many physicians, at least until the beginning of the 20th century, regarded emotions as important for the development and course of disease. Actually, such arbitrary exclusion is an acceptable strategy in scientific research, especially when concepts and methods appropriate for the excluded areas are not yet available. But it becomes counterproductive when such strategy becomes policy and the area originally put aside for practical reasons is permanently excluded, if not forgotten altogether. The greater the success of the narrow approach the more likely is this to happen. The biomedical approach to disease has been successful beyond all expectations, but at a cost. For in serving as guideline and justification for medical care policy, biomedicine has also contributed to a host of problems, which I shall consider later.

Limitations of the Biomedical Model

We are now faced with the necessity and the challenge to broaden the approach to disease to include the psychosocial without sacrificing the enormous advantages of the biomedical approach. On the importance of the latter all agree, the reductionist, the exclusionist, and the heretic. In a recent critique of the exclusionist position, Kety put the contrast between the two in such a way as to help define the issues (*9*). "According to the medical model, a human illness does not become a specific disease all at once and is not equivalent to it. The medical model of an illness is a process that moves from the recognition and palliation of symptoms to the characterization of a specific disease in which the etiology and pathogenesis are known and treatment is rational and specific." Thus taxonomy progresses from symptoms, to clusters of symptoms, to syndromes, and finally to diseases with specific pathogenesis and pathology. This sequence accurately describes the successful application of the scientific method to the elucidation and the classification into discrete entities of disease in its generic sense (*5, 6*). The merit of such an approach needs no argument. What do require scrutiny are the distortions introduced by the reductionistic tendency to regard the specific disease as adequately, if not best, characterized in terms of the smallest isolable component having causal implications, for example, the biochemical: or even more critical, is the contention that the designation "disease" does not apply in the absence of perturbations at the biochemical level.

Kety approaches this problem by comparing diabetes mellitus and schizophrenia as paradigms of somatic and mental diseases, pointing out the appropriateness of the medical model for both. "Both are symptom clusters or syndromes, one described by somatic and biochemical abnormalities, the other by psychological. Each may have many etiologies and shows a range of intensity from severe and debilitating to latent or borderline. There is also evidence that genetic and environmental influences operate in the development of both." In this description, at least in reductionistic terms, the scientific characterization of diabetes is the more advanced in that it has progressed from the behavioral framework of symptoms to that of biochemical abnormalities. Ultimately, the reductionists assume schizophrenia will achieve a similar degree of resolution. In developing his position, Kety makes clear that he does not regard the genetic factors and biological processes in schizophrenia as are now known to exist (or may be discovered in the future) as the only important influences in its etiology. He insists that equally important is elucidation of "how experiential factors and their interactions with biological vulnerability make possible or prevent the development of schizophrenia." But whether such a caveat will suffice to counteract basic reductionism is far from certain.

The Requirements of a New Medical Model

To explore the requirements of a medical model that would account for the reality of diabetes and schizophrenia as human experiences as well as disease abstractions, let us expand Kety's analogy by making the assumption that a specific biochemical abnormality capable of being influenced pharmacologically exists in schizophrenia as well as in diabetes, certainly a plausible possibility. By obliging ourselves to think of patients with diabetes, a "somatic disease," and with schizophrenia, a "mental disease," in exactly the same terms, we will see more clearly how inclusion of somatic and psychosocial factors is indispensable for both; or more pointedly, how concentration on the biomedical and exclusion of the psychosocial distorts perspectives and even interferes with patient care.

1) In the biomedical model, demonstration of the specific biochemical deviation is generally regarded as a specific diagnostic criterion for the disease. Yet in terms of the human experience of illness, laboratory documentation may only indicate disease potential, not the actuality of the disease at the time. The abnormality may be present yet the patient not be ill. Thus the presence of the biochemical defect of diabetes or schizophrenia at best defines a necessary but not a sufficient condition for the occurrence of the human experience of the disease, the illness. More accurately, the biochemical defect constitutes but one factor among many, the complex interaction of which ultimately may culminate in active disease or manifest illness (*10*). Nor can the biochemical defect be made to account for all of the illness, for full understanding requires additional concepts and frames of reference. Thus, while the diagnosis of diabetes is first suggested by certain core clinical manifestations, for example, polyuria, poly-

dipsia, polyphagia, and weight loss, and is then confirmed by laboratory documentation of relative insulin deficiency, how these are experienced and how they are reported by any one individual, and how they affect him, all require consideration of psychological, social, and cultural factors, not to mention other concurrent or complicating biological factors. Variability in the clinical expression of diabetes as well as of schizophrenia, and in the individual experience and expression of these illnesses, reflects as much these other elements as it does quantitative variations in the specific biochemical defect.

2) Establishing a relationship between particular biochemical processes and the clinical data of illness requires a scientifically rational approach to behavioral and psychosocial data, for these are the terms in which most clinical phenomena are reported by patients. Without such, the reliability of observations and the validity of correlations will be flawed. It serves little to be able to specify a biochemical defect in schizophrenia if one does not know how to relate this to particular psychological and behavioral expressions of the disorder. The biomedical model gives insufficient heed to this requirement. Instead it encourages bypassing the patient's verbal account by placing greater reliance on technical procedures and laboratory measurements. In actuality the task is appreciably more complex than the biomedical model encourages one to believe. An examination of the correlations between clinical and laboratory data requires not only reliable methods of clinical data collection, specifically high-level interviewing skills, but also basic understanding of the psychological, social, and cultural determinants of how patients communicate symptoms of disease. For example, many verbal expressions derive from bodily experiences early in life, resulting in a significant degree of ambiguity in the language patients use to report symptoms. Hence the same words may serve to express primary psychological as well as bodily disturbances, both of which may coexist and overlap in complex ways. Thus, virtually each of the symptoms classically associated with diabetes may also be expressions of or reactions to psychological distress, just as ketoacidosis and hypoglycemia may induce psychiatric manifestations, including some considered characteristic of schizophrenia. The most essential skills of the physician involve the ability to elicit accurately and then analyze correctly the patient's verbal account of his illness experience. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social, and cultural as well as in anatomical, physiological, or biochemical terms (7).

3) Diabetes and schizophrenia have in common the fact that conditions of life and living constitute significant variables influencing the time of reported onset of the manifest disease as well as of variations in its course. In both conditions this results from the fact that psychophysiologic responses to life change may interact with existing somatic factors to alter susceptibility and thereby influence the time of onset, the severity, and the course of a disease. Experimental studies in animals amply document the role of early, previous, and current life experience in altering susceptibility to a wide variety of diseases even in the presence of a genetic predisposition (11). Cassel's demonstration of higher rates of ill health among populations exposed to incongruity between the demands of the social system in which they are living and working and the culture they bring with them provides another illustration among humans of the role of psychosocial variables in disease causation (12).

4) Psychological and social factors are also crucial in determining whether and when patients with the biochemical abnormality of diabetes or of schizophrenia come to view themselves or be viewed by others as sick. Still other factors of a similar nature influence whether or not and when any individual enters a health care system and becomes a patient. Thus, the biochemical defect may determine certain characteristics of the disease, but not necessarily the point in time when the person falls ill or accepts the sick role or the status of a patient.

5) "Rational treatment" (Kety's term) directed only at the biochemical abnormality does not necessarily restore the patient to health even in the face of documented correction or major alleviation of the abnormality. This is no less true for diabetes than it will be for schizophrenia when a biochemical defect is established. Other factors may combine to sustain patienthood even in the face of biochemical recovery. Conspicuously responsible for such discrepancies between correction of biological abnormalities and treatment outcome are psychological and social variables.

6) Even with the application of rational therapies, the behavior of the physician and the relationship between patient and physician powerfully influence therapeutic outcome for better or for worse. These constitute psychological effects which may directly modify the illness experience or indirectly affect underlying biochemical processes, the latter by virtue of interactions between psychophysiological reactions and biochemical processes implicated in the disease (11). Thus, insulin requirements of a diabetic patient may fluctuate significantly depending on how the patient perceives his relationship with his doctor. Furthermore, the successful application of rational therapies is limited by the physician's ability to influence and modify the patient's behavior in directions concordant with health needs. Contrary to what the exclusionists would have us believe, the physician's role is, and always has been, very much that of educator and psychotherapist. To know how to induce peace of mind in the patient and enhance his faith in the healing powers of his physician requires psychological knowledge and skills, not merely charisma. These too are outside the biomedical framework

The Advantages of a Biopsychosocial Model

This list surely is not complete but it should suffice to document that diabetes mellitus and schizophrenia as paradigms of "somatic" and "mental" disorders are entirely analogous and, as Kety argues, are appropriately conceptualized within the framework of a medical model of disease. But the existing biomedical model does not suffice. To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model. Its scope is determined by the historic function of the physician to establish whether the person soliciting help is "sick" or "well"; and if sick, why sick and in which ways sick; and then to develop a rational program to treat the illness and restore and maintain health.

The boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations. The traditional biomedical view, that biological indices are the ultimate criteria defining

disease, leads to the present paradox that some people with positive laboratory findings are told that they are in need of treatment when in fact they are feeling well, while others feeling sick are assured that they are well, that is, they have no "disease" (*5, 6*). A biopsychosocial model which includes the patient as well as the illness would encompass both circumstances. The doctor's task is to account for the dysphoria and the dysfunction which lead individuals to seek medical help, adopt the sick role, and accept the status of patienthood. He must weight the relative contributions of social and psychological as well as of biological factors implicated in the patient's dysphoria and dysfunction as well as in his decision to accept or not accept patienthood and with it the responsibility to cooperate in his own health care.

By evaluating all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as "illness" conditions which others regard merely as "problems of living," be they emotional reactions to life circumstances or somatic symptoms. For from the individual's point of view his decision between whether he has a "problem of living" or is "sick" has basically to do with whether or not he accepts the sick role and seeks entry into the health care system, not with what, in fact, is responsible for his distress. Indeed, some people deny the unwelcome reality of illness by dismissing as "a problem of living" symptoms which may in actuality be indicative of a serious organic process. It is the doctor's, not the patient's, responsibility to establish the nature of the problem and to decide whether or not it is best handled in a medical framework. Clearly the dichotomy between "disease" and "problems of living" is by no means a sharp one, either for patient or for doctor.

When Is Grief a Disease?

To enhance our understanding of how it is that "problems of living" are experienced as illness by some and not by others, it might be helpful to consider grief as a paradigm of such a borderline condition. For while grief has never been considered in a medical framework, a significant number of grieving people do consult doctors because of disturbing symptoms, which they do not necessarily relate to grief. Fifteen years ago I addressed this question in a paper entitled "Is grief a disease? A challenge for medical research" (*13*). Its aim too was to raise questions about the adequacy of the biomedical model. A better title might have been, "When is grief a disease?," just as one might ask when schizophrenia or when diabetes is a disease. For while there are some obvious analogies between grief and disease, there are also some important differences. But these very contradictions help to clarify the psychosocial dimensions of the biopsychosocial model.

Grief clearly exemplifies a situation in which psychological factors are primary; no preexisting chemical or physiological defects or agents need be invoked. Yet as with classic diseases, ordinary grief constitutes a discrete syndrome with a relatively predictable symptomatology which includes, incidentally, both bodily and psychological disturbances. It displays the autonomy typical of disease: that is, it runs its course despite the sufferer's efforts or wish to bring it to a close. A consistent etiologic factor can be identified, namely, a significant loss. On the other hand, neither the sufferer nor society has ever dealt with ordinary grief as an illness even though such expressions as "sick with grief" would indicate some connection in people's minds. And while every culture makes provisions for the mourner, these have generally been regarded more as the responsibility of religion than of medicine.

On the face of it, the arguments against including grief in a medical model would seem to be the more persuasive. In the 1961 paper I countered these by comparing grief to a wound. Both are natural responses to environmental trauma, one psychological, the other physical. But even at the time I felt a vague uneasiness that this analogy did not quite make the case. Now 15 years later a better grasp of the cultural origins of disease concepts and medical care systems clarifies the apparent inconsistency. The critical factor underlying man's need to develop folk models of disease, and to develop social adaptations to deal with the individual and group disruptions brought about by disease, has always been the victim's ignorance of what is responsible for his dysphoric or disturbing experience (*5, 6*). Neither grief nor a wound fits fully into that category. In both, the reasons for the pain, suffering, and disability are only too clear. Wounds or fractures incurred in battle or by accident by and large were self-treated or ministered to with folk remedies or by individuals who had acquired certain technical skills in such matters. Surgery developed out of the need for treatment of wounds and injuries and has different historical roots than medicine, which was always closer in origin to magic and religion. Only later in Western history did surgery and medicine merge as healing arts. But even from earliest times there were people who behaved as though grief-stricken, yet seemed not to have suffered any loss; and others who developed what for all the world looked like wounds or fractures, yet had not been subjected to any known trauma. And there were people who suffered losses whose grief deviated in one way or another from what the culture had come to accept as the normal course; and others whose wounds failed to heal or festered or who became ill even though the wound had apparently healed. Then, as now, two elements were crucial in defining the role of patient and physician and hence in determining what should be regarded as disease. For the patient it has been his not knowing why he felt or functioned badly or what to do about it, coupled with the belief or knowledge that the healer or physician did know and could provide relief. For the physician in turn it has been his commitment to his professional role as healer. From these have evolved sets of expectations which are reinforced by the culture, though these are not necessarily the same for patient as for physician.

A biopsychosocial model would take all of these factors into account. It would acknowledge the fundamental fact that the patient comes to the physician because either he does not know what is wrong or, if he does, he feels incapable of helping himself. The psychobiological unity of man requires that the physician accept the responsibility to evaluate whatever problems the patient presents and recommend a course of action, including referral to other helping professions. Hence the physician's basic professional knowledge and skills must span the social, psychological, and biological, for his decisions and actions on the patient's behalf involve all three. Is the patient suffering normal grief or melancholia? Are the fatigue and weakness of the woman who recently lost her husband conversion symptoms, psychophysiological reactions, manifestations of a somatic disorder, or a combination of these? The patient soliciting the aid of a physician must have confidence that the M.D. degree has indeed rendered that physician competent to make such differentiations.

A Challenge for Both Medicine and Psychiatry

The development of a biopsychosocial medical model is posed as a challenge for both medicine and psychiatry. For despite the enormous gains which have accrued from biomedical research, there is a growing uneasiness among the public as well as among physicians, and especially among the younger generation, that health needs are not being met and that biomedical research is not having a sufficient impact in human terms. This is usually ascribed to the all too obvious inadequacies of existing health care delivery systems. But this certainly is not a complete explanation, for many who do have adequate access to health care also complain that physicians are lacking in interest and understanding, are preoccupied with procedures, and are insensitive to the personal problems of patients and their families. Medical institutions are seen as cold and impersonal; the more prestigious they are as centers for biomedical research, the more common such complaints (*14*). Medicine's unrest derives from a growing awareness among many physicians of the contradiction between the excellence of their biomedical background on the one hand and the weakness of their qualifications in certain attributes essential for good patient care on the other (*7*). Many recognize that these cannot be improved by working within the biomedical model alone.

The present upsurge of interest in primary care and family medicine clearly reflects disenchantment among some physicians with an approach to disease that neglects the patient. They are now more ready for a medical model which would take psychosocial issues into account. Even from within academic circles are coming some sharp challenges to biomedical dogmatism (*8*, *15*). Thus Holman ascribes directly to biomedical reductionism and to the professional dominance of its adherents over the health care system such undesirable practices as unnecessary hospitalization, overuse of drugs, excessive surgery, and inappropriate utilization of diagnostic tests. He writes, "While reductionism is a powerful tool for understanding, it also creates profound misunderstanding when unwisely applied. Reductionism is particularly harmful when it neglects the impact of nonbiological circumstances upon biologic processes." And, "Some medical outcomes are inadequate not because appropriate technical interventions are lacking but because our conceptual thinking is inadequate" (*15*). How ironic it would be were psychiatry to insist on subscribing to a medical model which some leaders in medicine already are beginning to question.

Psychiatrists, unconsciously committed to the biomedical model and split into the warring camps of reductionists and exclusionists, are today so preoccupied with their own professional identity and status in relation to medicine that many are failing to appreciate that psychiatry now is the only clinical discipline within medicine concerned primarily with the study of man and the human condition. While the behavioral sciences have made some limited incursions into medical school teaching programs, it is mainly upon psychiatrists, and to a lesser extent clinical psychologists, that the responsibility falls to develop approaches to the understanding of health and disease and patient care not readily accomplished within the more narrow framework and with the specialized techniques of traditional biomedicine. Indeed, the fact is that the major formulations of more integrated and holistic concepts of health and disease proposed in the past 30 years have come not from within the biomedical establishment but from physicians who have drawn upon concepts and methods which originated within psychiatry, notably the psychodynamic approach of Sigmund Freud and psychoanalysis and the reaction-to-life-stress approach of Adolf Meyer and psychobiology (*16*). Actually, one of the more lasting contributions of both Freud and Meyer has been to provide frames of reference whereby psychological processes could be included in a concept of disease. Psychosomatic medicine—the term itself a vestige of dualism—became the medium whereby the gap between the two parallel but independent ideologies of medicine, the biological and the psychosocial, was to be bridged. Its progress has been slow and halting, not only because of the extreme complexities intrinsic to the field itself, but also because of unremitting pressures, from within as well as from without, to conform to scientific methodologies basically mechanistic and reductionistic in conception and inappropriate for many of the problems under study. Nonetheless, by now a sizable body of knowledge, based on clinical and experimental studies of man and animals has accumulated. Most, however, remains unknown to the general medical public and to the biomedical community and is largely ignored in the education of physicians. The recent solemn pronouncement by an eminent biomedical leader (*2*) that "the emotional content of organic medicine [has been] exaggerated" and "psychosomatic medicine is on the way out" can only be ascribed to the blinding effects of dogmatism.

The fact is that medical schools have constituted unreceptive if not hostile environments for those interested in psychosomatic research and teaching, and medical journals have all too often followed a double standard in accepting papers dealing with psychosomatic relationships (*17*). Further, much of the work documenting experimentally in animals the significance of life circumstances or change in altering susceptibility to disease has been done by experimental psychologists and appears in psychology journals rarely read by physicians or basic biomedical scientists (*11*).

General Systems Theory Perspective

The struggle to reconcile the psychosocial and the biological in medicine has had its parallel in biology, also dominated by the reductionistic approach of molecular biology. Among biologists too have emerged advocates of the need to develop holistic as well as reductionistic explanations of life processes, to answer the "why?" and the "what for?" as well as the "how?" (*18*, *19*). Von Bertalanffy, arguing the need for a more fundamental reorientation in scientific perspectives in order to open the way to holistic approaches more amenable to scientific inquiry and conceptualization, developed general systems theory (*20*). This approach, by treating sets of related events collectively as systems manifesting functions and properties on the specific level of the whole, has made possible recognition of isomorphies across different levels of organization, as molecules, cells, organs, the organism, the person, the family, the society, or the biosphere. From such isomorphies can be developed fundamental laws and principles that operate commonly at all levels of organization, as compared to those which are unique for each. Since systems theory holds that all levels of organization are linked to each other in a hierarchical relationship so that change in one affects change in the others, its adoption as a scientific approach should do much to mitigate the holist-reductionist dichotomy and improve communication across scientific disciplines. For medicine, systems theory provides a conceptual approach suitable not only for the proposed biopsychosocial concept of disease but also for studying disease and medical care as interrelated processes (*10*, *21*). If

and when a general-systems approach becomes part of the basic scientific and philosophic education of future physicians and medical scientists, a greater readiness to encompass a biopsychosocial perspective of disease may be anticipated.

Biomedicine as Science and as Dogma

In the meantime, what is being and can be done to neutralize the dogmatism of biomedicine and all the undesirable social and scientific consequences that flow therefrom? How can a proper balance be established between the fractional-analytic and the natural history approaches, both so integral for the work of the physician and the medical scientist (*22*)? How can the clinician be helped to understand the extent to which his scientific approach to patients represents a distinctly "human science," one in which "reliance is on the integrative powers of the observer of a complex nonreplicable event and on the experiments that are provided by history and by animals living in particular ecological settings," as Margaret Mead puts it (*23*)? The history of the rise and fall of scientific dogmas throughout history may give some clues. Certainly mere emergence of new findings and theories rarely suffices to overthrow well-entrenched dogmas. The power of vested interests, social, political, and economic, are formidable deterrents to any effective assault on biomedical dogmatism. The delivery of health care is a major industry, considering that more than 8 percent of our national economic product is devoted to health (*2*). The enormous existing and planned investment in diagnostic and therapeutic technology alone strongly favors approaches to clinical study and care of patients that emphasize the impersonal and the mechanical (*24*). For example, from 1967 to 1972 there was an increase of 33 percent in the number of laboratory tests conducted per hospital admission (*25*). Planning for systems of medical care and their financing is excessively influenced by the availability and promise of technology, the application and effectiveness of which are often used as the criteria by which decisions are made as to what constitutes illness and who qualifies for medical care. The frustration of those who find what they believe to be their legitimate health needs inadequately met by too technologically oriented physicians is generally misinterpreted by the biomedical establishment as indicating "unrealistic expectations" on the part of the public rather than being recognized as reflecting a genuine discrepancy between illness as actually experienced by the patient and as it is conceptualized in the biomedical mode (*26*). The professionalization of biomedicine constitutes still another formidable barrier (*8*, *15*). Professionalization has engendered a caste system among health care personnel and a peck order concerning what constitute appropriate areas for medical concern and care, with the most esoteric disorders at the top of the list. Professional dominance "has perpetuated prevailing practices, deflected criticisms, and insulated the profession from alternate views and social relations that would illuminate and improve health care" (*15*, p. 21). Holman argues, not unconvincingly, that "the Medical establishment is not primarily engaged in the disinterested pursuit of knowledge and the translation of that knowledge into medical practice; rather in significant part it is engaged in special interest advocacy, pursuing and preserving social power" (*15*, p. 11).

Under such conditions it is difficult to see how reforms can be brought about. Certainly contributing another critical essay is hardly likely to bring about any major changes in attitude. The problem is hardly new, for the first efforts to introduce a more holistic approach into the undergraduate medical curriculum actually date back to Adolph Meyer's program at Johns Hopkins, which was initiated before 1920 (*27*). At Rochester, a program directed to medical students and to physicians during and after their residency training, and designed to inculcate psychosocial knowledge and skills appropriate for their future work as clinicians or teachers, has been in existence for 30 years (*28*). While difficult to measure outcome objectively, its impact, as indicated by a questionnaire on how students and graduates view the issues involved in illness and patient care, appears to have been appreciable (*29*). In other schools, especially in the immediate post–World War II period, similar efforts were launched, and while some flourished briefly, most soon faded away under the competition of more glamorous and acceptable biomedical careers. Today, within many medical schools there is again a revival of interest among some faculty, but they are few in number and lack the influence, prestige, power, and access to funding from peer review groups that goes with conformity to the prevailing biomedical structure.

Yet today, interest among students and young physicians is high, and where learning opportunities exist they quickly overwhelm the available meager resources. It would appear that given the opportunity, the younger generation is very ready to accept the importance of learning more about the psychosocial dimensions of illness and health care and the need for such education to be soundly based on scientific principles. Once exposed to such an approach, most recognize how ephemeral and insubstantial are appeals to humanism and compassion when not based on rational principles. They reject as simplistic the notion that in past generations doctors understood their patients better, a myth that has persisted for centuries (*30*). Clearly, the gap to be closed is between teachers ready to teach and students eager to learn. But nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care. The proposed biopsychosocial model provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care. Whether it is useful or not remains to be seen. But the answer will not be forthcoming if conditions are not provided to do so. In a free society, outcome will depend upon those who have the courage to try new paths and the wisdom to provide the necessary support.

Summary

The dominant model of disease today is biomedical, and it leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. A biopsychosocial model is proposed that provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care.

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Second Phases in Steel

New analytical methods can identify the types and amounts of complex precipitates in steel.

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For many years better analytical methods for the determination of second phases in steel have been needed, because these phases are often more closely related to the heat treatment and mechanical properties of the steel than the elemental composition. I discuss here some of the recent approaches to solving this problem.

Ever since steel was first manufactured, metallurgists have been searching for methods of changing its mechanical properties so that specific grades can be made for particular applications. Often such changes are brought about by the addition of one or more alloying elements to the steel, and at least 35 elements have been added for this purpose. Most of these elements can be present in solid solution in iron, but they often change the mechanical properties of the steel by combining with oxygen, nitrogen, carbon, or sulfur to form precipitates in the steel that are referred to as second-phase compounds. Sometimes the second phase will contain two metals such as nickel and titanium combining to form Ni_3Ti, but most often the second phases are oxides, nitrides, carbides, sulfides, carbonitrides, carbosulfides, and similar compounds. These compounds may be formed in the molten bath, during solidification, during rolling or forming, during heat treatment, and sometimes even during storage at ambient temperature.

Table 1 shows how precipitates can affect some of the mechanical and physical properties of steel. Only a portion of the approximately 200 precipitates found in low-alloy, high-alloy, and specialty steels and some of the important mechanical properties are listed. Often metallurgists can associate precipitates with additional changes in the mechanical, physical, and chemical properties of steel. No attempt has been made in Table 1 to note whether a particular precipitate has a detrimental or beneficial effect on the mechanical properties of steel because in many instances the effect can be either positive or negative depending on the amount, size, and distribution of the precipitate. Precipitate concentration can vary from as much as 10 percent (by weight) (cementite, Fe_3C) to as little as 0.002 percent [boron nitride (BN) and ferrous sulfide (FeS)].

The determination of where a precipitate is located in the iron matrix is of great importance in terms of what effect it can have on the properties of the steel. Even very small quantities of a precipitate located at a grain boundary can induce cracking or corrosion, whereas a larger amount of the same material located randomly throughout the steel will not have the same effect. Small particles of carbide or nitride arranged in rows will form a barrier to slip and dislocation movement in the crystals of the iron matrix and are therefore much more effective in conferring strength than randomly arranged particles.

The particle size of the precipitated phase is also important. As an example, the strength of a steel is changed more by particles of carbide and nitride that are 30 to 400 angstroms in size than by larger particles because these smaller particles are much more effective in preventing grain growth, and fine-grained steels are stronger. Frequently very large particles of carbide or nitride are detrimental to the steel, whereas small particles of the same compound can be beneficial.

The magnitude of the analytical chemical problem can be appreciated when one realizes that more than 50 nitrogen compounds can be present in simple and complex steels. These include simple nitrides such as titanium nitride (TiN) or more complex nitrides such as niobium carbonitride (NbC_xN_y), manganese silicon nitride [$(MnSi)N_2$], and aluminum oxynitride (AlO_xN_y). A like number of carbides and oxides and a smaller number of sulfides and carbosulfides may also be found in steels. There are thus several hundred compounds that can exist in the carbon, alloy, and specialty steels presently being produced in the United States. As a result, the identification and determination of second-phase compounds in steel have been a real challenge in the development of improved steels.

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Domestic Violence: A Diagnosis of High Prevalence

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Overview of Assessment, Incidence and Definitions of Family Violence

Violence in families is being increasingly recognized as highly prevalent and is viewed as a significant variable in the overall health of individual family members. It is also a very frequently-missed diagnosis in the medical assessment of patients both in the emergency room setting and in primary care offices. Family physicians are often the first health care providers consulted about symptoms resulting from family violence. Residents in training need to evaluate the possibility that symptoms are abuse-related both in the emergency room and in office practice. Recent empirical studies have demonstrated that physicians often are not accurately identifying patients who are victims of abuse. It is assumed that the lack of structured, systematic approaches to diagnosis in this area, along with a "conceptual blind spot" about the prevalence of abuse, are responsible for these diagnostic omissions.

Family physicians need exposure to protocols for accurate diagnosis of various types of family violence: (a) elder abuse (b) child abuse: emotional, physical, and sexual; and (d) spouse/partner abuse. Interviewing approaches which assist in identifying violence without immediately alienating family members will be emphasized. The role of family physicians, the role of their psychotherapist colleagues, and the role of state protection services need to be clarified and methods to develop an integrated approach delineated. The goal of assessment is, of course, to have a high degree to sensitivity to situations in which abuse is present. On the other hand, the practitioner must be aware that false allegations of abuse do occur, and accurate assessment will take this into consideration. The special instance of child custody disputes and false allegations of abuse during the divorce process is now recognized as an important dynamic related to the parental alienation syndrome.

It has also become apparent that concern about possible abuse is influenced by sociocultural characteristics of patients. Families from different sociodemographic suburban families, trigger different responses in health care providers. Difficulties encountered by providers with different life experiences and/or ethnic or social background from their patients and the role of these differences in assessing abuse are important to recognize. The following outline details material about the major forms of family violence. Definitions, assessment techniques, and references are included for each area.

Definition and Prevalence of Family Violence

A general definition is: those acts that result or are likely to result in physical injury (Straus, 1980). Additionally, a family is defined as "violent" if at least one violent act occurred within last year (Crelles, Straus, 1985). Acts of minor violence have a potential for causing serious injury, for example: pushing, shoving, slapping, and throwing things. Acts of severe violence have a high likelihood of causing serious injury, such as kicking, biting, punching, hitting with an object, "beating-up," and attacking with knife or gun.

At least 2.2 million Americans are victims of violent medical injury each year. The U.S. ranks first among industrialized nations in violent death. Deaths caused by violent and unintentional misuse of firearms exceed in number the combined total of the next 17 nations (U.S. Dept. of Health and Human Services, 1991). Both suicide and homicide constitute the 4th leading cause of lives lost to people prior to age 65 in the U.S. Suicide is the 3rd leading cause of death among people between the ages of 14-34. Violent death and abusive behavior are an important cause of injury-related death and long-terms disability.

National Objectives for Reducing Violence and Abusive Behavior

A national focus was developed in 1985 by Surgeon General and U.S. Public Health Service to focus on violence as a leading public health problem. The federal government has involvement through U.S. Dept of Health and Human Services, with the goal of reducing various forms of family violence by year 2000. Specific objectives for this public health problem focuses on six key areas: 1) Homicide and assaultive violence, 2) Domestic violence (partner and elder abuse), 3) Child abuse, 4) Sexual assault, 5) Suicide, and 6) Firearm injury. Several needs are to be emphasized in national health policy, including establishing effective services for victims that address the physical and psychosocial consequences of abuse.

Physical Child Abuse

Incidence and Consequences

There has been a steady yearly increase in child abuse with over one million cases reported in the United States per year. In spite of better reporting, no one really knows the true incidence of abuse, since injuries are often explained as "accidents." Physicians (family practice & pediatricians) are often the first persons to come in contact with evidence of child maltreatment. Studies have shown that in emergency rooms: 1)12% of trauma in E.R. visits by children cannot be explained by parents and 2) Reinhurst (1980) documented that 22.5% of infants under 13 mos of age in E.R. had injuries ssuspected to be secondary to abuse.

The mortality & morbidity data (National Study on Child Abuse Reporting) regarding the physical abuse of children is important for physicians to recall: 1) Death rate among physically abused children is 4-5% and 2) Permanent injury occurs in about 30-35% without prompt treatment.

Physical Indicators of Physical Abuse/Neglect

There are distinctive physical signs of abuse in children. The recommendations are to examine children carefully for the following findings:
1) Bruises and welts: a) on face, lips, or mouth; b) in various stages of healing; c) on large areas of the torso, back, buttocks or thighs; and d) unusual patterns, clustered, or reflective of the instrument used to inflict them.

2) Burns: a) cigar or cigarette burns; b) glove or socklike burns or doughnut-shaped burns of the buttocks or genitalia--suggests immersion in hot water
3) Fractures: a) skull, jaw or nasal fractures; b) spiral fractures of the long bones (arm or leg): c) fractures in various stages of healing; d) multiple fractures; or e) any fracture of child under age two
4) Lacerations or abrasions: a) mouth, lip, gums, or eye; or b) external genitalia
5) Human bite marks

Child's Behavior

There are findings that indicate a high likelihood of domestic violence and physical abuse in children. Although some of these behaviors can be associated with children who have not been abused, they should raise the physicians level of concern:

1) Wary of physical contact with adults
2) Apprehensive when other children cry
3) Demonstrates extremes in behavior, including aggressiveness or extreme withdrawal
4) Seems frightened of parents/other caretakers
5) Reports injury by parents/caretakers
6) Rarely attends school or uneven attendance
7) Begins engaging in a pattern of delinquency, including vandalism, prostitution, or drug use.

Characteristics of Abusive Parents

Who are the people who abuse their children? There are many areas of a parent's characteristics, behavior, or circumstances that have been shown to be related to a higher likelihood of physically abusing a child. Practitioners should look for these patterns in assessing families:

1) Less than 10% are psychotic or psychopathic--debunk myth
2) More than 90% are "common folk"
3) Most overwhelmed by role of parenthood - React to crises (large or small) by abuse
4) Most are amenable to treatment
5) Abuse often symptom of other problems: Abusers project problems onto children
6) Misuses alcohol or other drugs
7) May have history of abuse as a child (Only 30% of abused do repeat cycle)
8) Uses harsh discipline, inappropriate to child's age, transgression or condition
9) Explanations of injury: illogical, unconvincing, contradictory, none
10) Seems unconcerned about child
11) Significantly misperceives child - sees child as bad, evil, a monster
12) Attempts to conceal child's injury or protect identity of person responsible
13) Maintains chaotic home life
14) May be family with several long-term chronic illnesses
15) Appears to be under severe stress/anxiety due to finances
16) Blames and belittles child
17) Appears to have a cold, rejecting interpersonal style

Predisposing Factors in Abuser/Network

There are four discrete areas on which the clinician should focus in clinical interviews of family members when physical child abuse is under consideration:

Individual Assessment
1) Abused as child
2) Unmet dependency needs
3) Substance abuser
4) Impaired impulse control
5) Poor self-image
6) Inadequate defenses

Familial
1) Unstable marriage or relationship
2) Spouse abuse in family
3) Isolation from other support networks

Social Assessment
1) Substandard social network/support neighborhood, school, kinship, church activities/resources
2) Problems in housing situation
3) Problems in employment status; time allotments

Cultural Assessment
1) Assess view of discipline;e.g., potty training, corporal punishment
2) Assess views about violence
3) General attitudes toward child-rearing

Sexual Child Abuse

Definition, Incidence and Patterns

Sexual child abuse involves the participation of a child or an adolescent in sexual activities that they do not understand given their developmental stage, to which they cannot give consent or that violate the social taboos or laws of our society. The range of activities includes visual or noninvasive activities such as exhibitionism of an adult or coercing the child to have erotic films made, to fondling by or of the adult, to brutal penetration of bodily orifices.

From a legal perspective, one must have documented physical evidence, identification of abuse by the victim, or acknowledgement by the child abuser, in order to have a legal case against a perpetrator. For purposes of referring the child or family to protective services or for counseling, the physician need only have a suspicion that sexual abuse has occurred.

The courts seem to be more protective of children in terms of separation of the victim from perpetrator in the case of sexual abuse, as compared to physical abuse. Goldberg, Wall, and Commerford (1990) describe a case of suspected, unconfirmed sexual abuse in which the father also presented a physical danger to his family (while displaying a gun, he threatened to kill all of them); the daughter was returned to his care, as the father passed polygraph test regarding the abuse.

It is debatable whether the incidence of sexual abuse is rising, or if there is an increased emphasis placed on the problem by health officials. A report compared recent statistics in the 1970's and 1980's to those reported by Kinsey's work in 1953 and concluded that the most methodologically sound projects yielded results of no significant increase in child sexual abuse. The stable

incidence reported is that 10-12% of girls younger than 14 experience sexual abuse by a perpetrator at least 5 years older than the girl. Other researchers have estimated that incidence to be closer to 25% for girls and 10% for boys.

Familial incest is more common than stranger molestation. Some researchers have reported that sexual abuse appears to be more prevalent than physical abuse or battery. The median age of the child is 11 years of age. Ten girls are molested for every one boy; while 97% of the abusers of both genders are males. Seventy-five percent of the offenders were known to the child or family; 27% lived in the home (father, stepfather, mother's partner, brother); another 11 related by blood or marriage; less than 25% were total strangers. The offenders ranged in age from 17 to 68 years, with a median of 31 years; more than 30% were under 24, 60% were under 34 and 10% were over 50. Fathers comprised 27 percent of one sample, evenly divided between natural and stepfathers. In more than 40% of cases, abuse continued from weeks to years. Force or the threat of force was used in 60% of the cases. In 25%, the lure was more subtle, based on the child's natural loyalty and affection. In 15%, money or gifts were offered.

Sexual Abuse is Color-Blind and Income-Blind

Debunking a popular myth that ethnicity and socioeconomic status are strong influences on sexual abuse, most studies have documented that "race and social class do not appear to be related to childhood sexual abuse" (Felman et al, 1991, p 32).

Presentations of Abuse:

There are often no clear symptoms; Children are often coerced into secrecy, so symptoms not clear. There are several general, nonspecific symptoms often associated with sexual abuse: sleep problems, phobia, enuresis, encopresis. Psychological symptoms: which are actually consequences of abuse, include: lowered self-esteem, mistrust of adults, guilt, depression, suicidal ideation, delinquency, acting out, and running away. More specific signs and symptoms: rectal or genitalia pain, bleeding or infection, STDs, and developmentally precocious sexual behavior.

Assessment and Interviewing Children

Physicians are urged to consult the guidelines for interviewing published by the American Academy of Child and Adolescent Psychiatry.

Two sets of statements and questions are important to include on a pediatric examination with a child on a periodic basis. These do not even mention sex and yet will prompt questions or statements from children who have been sexually abused.

"I am a doctor and am an expert about bodies. Do you have any questions about your body or kid's bodies? and how they work?

"Adults have bodies that are different from kids. Do you have any questions about adult's bodies? and how they work?

The interviewing style should include: a) Using nonleading questions; b) Maintaining a calm, unemotional, but empathic demeanor; c) Encouraging child with nonverbal behavior, openness and rapt attention; d) Encouraging child with paraverbal signs: "uh huh," "go on," "okay," "yes"; and e) Encouraging child with verbal statements: "Tell me more about that." "What happened after that?"

Drawings, dolls, and other interviewing aids can be helpful, especially with very young children. However, the provider should check rules in each state, as some jurisdictions consider these to be "leading the witness," and may ruin a case against a perpetrator in court.

Parents and other caretakers should be interviewed separately. False allegations of abuse have become an issue, especially during divorce, custody and visitation hearings. It is important to take all allegations of abuse seriously, but to realize that in custody considerations, up to 25% of allegations may be false.

Physical Examination

The physician should try to avoid further emotional trauma while examining the child. It is best to perform the exam in the presence of a supportive adult not suspected in the abuse.The exam should focus on trauma in areas involved in sexual acts: mouth, breasts, genitals, perineal area, buttocks an anus. Physical Findings Suggestive of Child Abuse (American Academy of Pediatrics, 1991) include:

(1) chafing, abrasions, or bruising of the inner thighs and genitalia
(2) scaring, tears, or distortion of the hymen
(3) a decreased amount of or absent hymenal tissue
(4) scarring of the fossa navicularis
(5) injury to or scarring of the posterior fourchette
(6) scarring or tears of the labia minora, and
(7) hymenal enlargement (see Cantwell, 1987)
(8) bruises around anus
(9) scars and anal tears, especially those that extend into surrounding perianal skin
(10) anal dilation and visual sphincter laxity

The differential of genital trauma or findings includes accidental injury, physical abuse, infectious processes, and congenital malformations. The physician should obtain a detailed history and consult with colleagues if the etiology is unclear. A regional child protection team or other experts can be consulted in case of confusing or contradictory findings. Do not do cultures for STDs routinely, only if history or physical findings suggest the possibility of direct contact. If history of sexual abuse with ejaculation within 72 hours, use standardized rape kit and adapt for child.

The physician should include detailed records, drawings and or photographs. Written reports to county agencies and law enforcement are an excellent idea; the more explicit the opinion, the less likely that the physician will need to testify for potential protective custody hearings. In criminal proceedings, the physician will have to testify.

Families undergoing evaluation of sexual abuse need mental health services. All children who have been sexually abused need supportive counseling. More extensive treatment depends on extent of the abuse (how violent, how long it occurred, and the closeness of the relationship of the child to the abuser). Parents and other family members, such as siblings, also require counseling; the extent of this depends on whether the situation involves an intrafamilial abuser or if the children were victims.

Spouse and Partner Abuse

Incidence and Patterns of Abuse

The incidence of spouse or partner abuse is astonishingly high to most primary care physicians. Some surveys have estimated that at least one act of violence occurs from husband to wife in 50 percent of marriages (Straus, Gelles, & Steinmetz, 1980). Other studies gauge the incidence of abuse as closer to a 40 percent lifetime incidence and a 25 percent frequency of abuse within the last year (Hamberger, Saunders & Hovey,1992). Although the highly publicized 1993 case of Lorena Bobbitt and John Wayne Bobbit noted the possibility of physical violence occurring from a wife toward her male partner, only 12% of spousal abuse is reciprocal, occurring in both directions between partners. As Burge (1989) has noted, there are two main ingredients that lead to the abuse of women. The first involves the inability of abusive men to deal constructively with anger; the second, the prevailing attitudes in the larger society that condone violence toward women.

The onset of marital abuse occurs normally within the first year of marriage. Straus and colleagues have reported that 49 percent of battered women saw their husband acting violently with others or were themselves assaulted by him before marriage. By the end of the first year of marriage, an average of 72 percent of women who had seen some evidence of premarital violence, had been abused. The majority of these battered women experience multiple assaults each year, with about 40 percent of them experiencing assaults on a weekly basis (Okun, 1986). A high level of regular abuse appears to be related to a number of identifiable factors.

Age--The largest number of assaults on wives occurs where the spouses are under the age of 30 and the wives are younger than their husbands. One possible reason for the shift of abuse towards the younger generation is the changing values among many of the younger women concerning divorce and sex roles (Okun, 1986). In a survey of men and women regarding the presence of family violence, Gin et al (1991) reported an incidence of 44 percent for current violence among respondents under 25 years of age, and an 11 percent incidence for those above 25. Okun (1986) further notes that the age discrepancy between husband and wife is an important one; apparently, the wife being older than her male spouse results in a lower abuse rate. Whereas, when the man is older than his spouse (the average being 3.4 years), the abuse rate is higher than in marriages without this age discrepancy.

Ethnicity.--Ethnicity is a significant variable in spouse abuse, as groups differ in attitudes and behaviors (Coley and Beckett, 1988). According to Straus (1986) the abuse rate among members of minority groups is over triple that of abuse within Caucasian marriages. In addition, Straus believes that the higher abuse rate in African-American marriages compared to Caucasian marriages has to do with the frustrations encountered by being black in a predominantly white American society. It has also been reported that the rate of abuse is even higher in other minority groups, such as Orientals, Mexicans, or Europeans (Lewis, 1987). However, the rate of self-reported abuse was not significantly different in Gin et al's (1991) sample of Spanish-speaking and non-Anglo participants than in English-speaking, Anglo subjects. The results may have been affected by the fact that a number of Spanish-speaking women were excluded from the study because of illiteracy. The authors theorize that illiteracy may be associated with a higher rate of domestic violence and a lower rate may have been found by excluding these women.

Socioeconomic Status.--The lower the income and occupational status of the couple, the higher the rate of partner abuse; the rate of violence in a marriage is double for blue collar workers in contrast to white collar workers (Okun, 1986) Other studies show that the most abusive relationships have a mean income well below the national average (Coleman, Weinman, & Hsi, 1980). Straus reported that families at or below the poverty level have a 500 percent increase in

the rate of violence compared to the upper classes (Lewis, 1987). In the Gin et al (1991) study, which included both indigent and affluent subjects, poverty was a significant predictor of domestic violence, as determined by logistic regression analysis.

The numerous studies cited have catalogued additional indicators that are associated with higher rates of domestic violence, as indicated in the table below.

Indicators of Domestic Violence
Female gender**
Young age: Less than 25-30**
Low Socioeconomic Status**
Minority Group Member
Unmarried status**
Recently separated or divorced
Woman younger than male partner
Victims or partners abuse alcohol and/or street drugs
Pregnancy
** most significant variables from the Gin et al (1991) study

Abused Partners in the Medical Care System

Recent reports have suggested that a high percentage of emergency room visits by women are for injuries sustained through domestic violence, but that they are not frequently assessed as assault incidents (Morrison, 1988; Raymond, 1989). Another study documented that approximately 30 percent of women visiting internal medical outpatient practices had been victims of partner abuse at some time in their lives, and that 44 percent of young adult patients and 11 percent of older patients were victims of current abuse (Gin, Rucker, Frayne, Gygan, & Hubbell, 1991). If physicians include partner abuse in their differential diagnosis of injuries (including unexplained abdominal pain), they will detect it. Pregnancy appears to be related to a high level of abuse; approximately 30 percent of pregnant women suffer physical abuse during the gestation of their child (Okun, 1986).

Hamberger, Saunders and Hovey (1992) document the rarity of physician inquiry into the problem of physical abuse. In their study of approximately 400 women seeking medical care from a family practice clinic, 22.7 percent had been physically abused by their partners within the last year, with a lifetime rate of physical abuse of 38.8 percent. Yet, only six women in the group had been asked about abuse by their health care providers. Although only about 2% of women report that their physicians asked about partner abuse at their most recent visit, patients who have had an extended office visit in the past had higher inquiry rates, ranging about 8 or 9 percent. Interesting, given the difference in possible medical consequences, more family physicians were shown to have inquired about relationship problems than about verbal or physical abuse (Hamberger et al, 1992)

In a Canadian study, Ferris and Tudiver reported that about half of family physician respondents believed that they should counsel patients who were abuse victims, as well as referring patients

for other appropriate services. Yet, only 13 to 19 percent of the physicians had a standard method for diagnosing wife abuse, even though half of them thought that a standard method for diagnosing and treating wife abuse would be helpful.

Understanding Why Women Do Not Leave Abusive Relationships

Economic.--There are three main reasons why women enter, tolerate, and stay in abusive relationships; these reasons are financial, financial, and financial. Economic considerations play the most important role; women experience extreme job and pay inequality, and many virtually are not able to support themselves and their children without a man in the household (Straus & Hotaling, 1980). Aguirre (1985) reported that 84 percent of women in a shelter whose spouse was their sole source of income planned on returning to him, while 82 percent of the wives whose husbands did not provide their only means of income planned to separate.

Family and Social Considerations.--Another major reason that women stay in abusive relationships relates to the preservation of family life and stability for children. In addition, the women experience little societal support for leaving. Society has placed a double bind on battered wives, they are often blamed for not seeking help, but "when they do, they are advised to go home and stop the inappropriate behavior, which causes their men to hurt them" (Okun, 1986). There is also a strong belief among battered women that the husband will be able to change and will cease being abusive (Holtsworth-Munroe, 1988), and that the situation will improve. Additionally, Ferraro and Johnson (1983) point out that women may be prompted to leave when they relinquish hope that the situation will get better. This diminution of hope is associated with a decrease in the partner's remorse and expressed love and an increase in the level of violence. Also, if the women experience a change in resources, such as a safe place to stay, they may be finally prompted to leave.

Personal.--It is important for the physician to understand that there are several reasons prompting women to remain in abusive relationships. One factor has to do with the personal sphere: Many women have low self-esteem and a lack of confidence related to their battering by spouses. Most abused women see themselves as relatively powerless and as trapped within their relationships. Since most battered women feel dependent on others (Okun, 1986), their personal initiative and personal assertiveness may not be sufficient to leave the relationship at the point that they are first evaluated. It is essential to emphasize that women do not stay because they have masochistic tendencies, as documented by Kuhl (1984). They may legitimately have ambivalent feelings about the abuser, experiencing feelings of love, as well as fear and disdain.

Emotional Disability.--The best explanation of why women stay in abusive relationships is because they suffer a form of Post-Traumatic Stress Disorder (PTSD), as described by Janoff-Bulman and Frieze (1983). As noted below, some of the symptoms characterizing abused women include re-experiencing the trauma in nightmares and flashbacks, a numbing of responsiveness to the external world, and a myriad of anxiety-related symptoms. From another perspective, they exhibit symptoms similar to those of kidnap victims or hostages (Hilberman (1980), including a distortion of reality and a pathological transference that often develops between kidnappers and victims. Symonds (1975) uses the analogy of the "Stockholm Syndrome," in which victims describe positive feelings toward their captors and negative feelings toward the rescuers. Women who are repeatedly abused experience threats against their life, damage to their property, and emotional degradation. The male abuser may then follow episodes of abuse with a "honeymoon" period in which he makes amends, promises to reform, and to love and cherish. It is perfectly understandable that the battered woman, like the political hostage, becomes dependent on her tormentor and may, in an ironic distortion of reality, view the assailant as her protector.

Determination of Possible Abuse

First, have a high index of suspicion, being ever cognizant of the incidence. It is important to recognize that many of assaults are severe. Hamberger et al (1992) report that during the past year, (a) 7.5 percent of women had been hit or an attempt was made to hit them with an object, (b) 3 percent received multiple blows, (c) more than 5 percent were choked, and (d) 3 percent were threatened or victimized with a knife or gun. The one year injury rate for all women due to domestic assault was 13.3 %, while the at-risk women had rate of 14.8%. During their lifetimes, 38.8 percent of the sample had been physically abused by an intimate partner. In terms of specific threats or actions, 19% were hit or almost hit by an object, 12% to 13 % were beaten and/or choked, and 10% were threatened with a knife or gun. The lifetime injury rate was 24.7%.

Physician Preparation for Handling Abused Patients

Physicians should have a high index of suspicion regarding partner abuse among all women patients, particularly those under 30 years of age or those who are pregnant. Asking some screening questions to all women is an appropriate area of inquiry for all women. The physician should follow inquiries about the patient's level of satisfaction with relationships, with statements and questions about abuse. "I am aware that women in this society are often victims of verbal or physical abuse by men. Have any events occurred that you consider to be abusive?" Additional questions are described below. Completing a comprehensive physical examination and carefully attending to headaches, earaches, and abdominal pain is crucial in any emergency room presentation by a woman.

It is important for physicians and other health care professionals to have completed some planning before an injured woman presents in th ic or hospital. For instance, the health care provider needs to know resources available i area, such as women and children's shelters and counseling facilities. It is also important to know legal requirements for obtaining restraining orders; if a woman is not able to obtain one on the first documented abuse incident, caution her about returning to her home. Florida has recently enacted a "stalking" law, and women are able to receive restraining orders if she has good reason to believe that someone may endanger her.

Questions to use on history:

Braham, Furniss, Holtz & Stevens (1986) list of questions for uncovering suspected abuse in women. They suggest that it is crucial to ask direct questions in a nonthreatening, empathetic manner. Examples of statements and questions from their list include:

I noticed you have a number of bruises. Could you tell me how they happened? Did someone hit you?

You seem frightened of your partner. Has he ever hurt you?

Many patients tell me they have been hurt by someone close to them. Could this be happening to you?

You mention your spouse loses his temper with the children. Does he ever lose his temper with you? Does he become abusive when he loses his temper?

Have there been times during your relationship when you have had physical fights?

Do your verbal fights ever include physical contact?

Your partner seems very concerned and anxious. Was he responsible for your injuries?

Other statements or questions validate the "normalcy" of abuse or its prevalence, so that the patient is not made to feel inferior or "different" if it is occurring in her family. Another option for assessment would be to use a written scale to assess the possibility of domestic violence, such as Kuhl's (1984) Domestic Violence Assessment Form. Additionally, if a physician has a patient complete a questionnaire that taps family functioning in several areas, such as the Family Apgar, it is then easy to query about anger and violence.

"So, you state, Mrs. Smith, that you do not feel that your family supports your efforts outside the home. Does your husband/partner not encourage you to spend time with others?"

"Tell me a little about what happens in your family when people are angry. For instance, are you a 'loud anger' or a 'quiet anger' family? "

" Do people lose their temper often or infrequently? Does the anger ever escalate to the point that one person might throw something or hit someone else?"

If the physician sees the children in a family, they are the perfect family members to ask about anger, especially if the physician claims that they have had experience with really noisy, "loud anger" families. Children often do not see the harm in describing the events to an empathetic, concerned physician; whereas, adults may be embarrassed or worried about the consequences of such a disclosure.

The "Stockholm Syndrome" consists of behavioral changes exhibited by kidnap victims and hostages. It is often characterized by a pathological transference that develops between abuser and victim; due to terror, development of a regressed dependence and gratitude. A woman may develop negative attitudes toward potential helpers and the distorted notion that her persecutor is her protector.

Characteristics of Abused Women

There is not a psychological prototype of an abused woman. According to Follingstad, et al (1980) "the population of battered women is a heterogeneous one that will react and cope in a vast range of ways with their experiences" (p. 387). Additionally, there is no empirical proof that abused women contribute to their own abuse by being aggressive, efficient, masculine, sexually frigid, controlling or castrating, nor by having a masochistic personality (Kuhl, 1984). On the other hand, Kuhl reports that these women do exhibit characteristics that appear to be a result of abuse: cautiousness, shyness, emotional blunting or low emotional expressivity, difficulty in coping with stress or trauma, and avoidance of confrontations.

Symonds (1979) review of research on victims of violent crime is relevant to the stages that abused women may experience. A three stage reaction pattern is described as: (1) initial phase of shock, disbelief and denial; (2) a second phase of acknowledging the reality wherein a state of terror sets in and the victim feels dependent, and (3) a period of depression with intermittent inner-directed rage and outbursts of anger. In all of these phases, the woman's emotional responses may profoundly influence her problem- solving ability and judgment. The long-term psychological effects of constant victimization include: a profound betrayal of trust; chronic tension; low ego strength and an impaired level of self-esteem; difficulty coping with aggression; feelings of guilt, shame, and inferiority, especially if verbal and emotional abuse are present along with the

physical; and a gradual replacement of love with loneliness and pessimism.

A table is included that contains a compilation of symptoms that researchers report as commonly occurring in physical abuse. They are categorized into different diagnostic groups, including physical, psychosocial, and cognitive.

Common Symptoms of Partner Abuse

Physical Findings:

physical injuries of all kind
especially injuries to the head
(headaches, earaches)
except in pregnancy, blows to the abdomen resulting in injury
psychosomatic complaints
vague pain reports
exaggerated startle reflex

Psychosocial Symptoms:

emotional blunting
sleep disturbance
anxiety
depression
terror
nightmares, flashbacks, intrusive thoughts
inability to handle anger
intense feelings of vulnerability
helplessness-hopelessness syndrome
lowered self-esteem
withdrawal from the external world
isolation from peers
shyness
reduced coping skills
avoidance of confrontation

Cognitive Symptoms:

a numbing of responsiveness to the external world
avoidance of any stimuli associated with the trauma
diminished decision-making and problem-solving
distortion of reality - the "Stockholm Syndrome"
denial and rationalization of injuries or partner responsibility

It is crucial for physicians to remember that severe depression and an increased risk of suicidality are also often present. Stark et al (1979) reported that there is a 25 percent suicide attempt rate after chronic abuse, whereas only 6 percent of these women had any attempts before the initial assault. Most battered women who attempt suicide do so with prescription overdoses, according to Gayfor (1975); 42 percent of her sample had attempted suicide. Furthermore, 71 percent of Gayfor's study group had received hypnotics, tranquilizers, or antidepressants. Stark et al (1979) found that victims of abuse are more likely to leave emergency rooms with some sort of prescription than other patients, including tranquilizers or pain medications. The medications were given whether or not they acknowledged the abuse. Hilberman and Munson (1977-78) found that most abused women had been treated periodically or consistently with sedative-hypnotics, tranquilizers and/or antidepressants.Self-destructive acts by the abused victims encourage health care providers to view the women as pathological; physicians then focus on the battered partner as the problem rather than the abusive partner who may be absent from the professional's clinic or hospital.

Coping strategies

Major coping strategies of abused women include substance abuse, denial, and a constant stance of learned helplessness. The findings delineated above about the prevalence of psychotropic drug prescriptions given to abused women are illuminating considering the risk of prescription drug abuse in battered women. In addition, abused women are at risk for abusing alcohol and illegal drugs, as are their partners.

Denial is pervasive and injurious to the woman and her responsiveness to help from the medical profession. She may: (a) deny the injury (It really did not hurt very much."), (b) rationalize the motives of the partner ("His job is very stressful."), (c) deny victimization ("It was really my fault for spending too much money."), and (d) deny alternative options ("I really can't leave, the children would be devastated.") Another form of denial has to do with belief that it is her job to stay and help the abuser; here the woman usually appeals to traditional or religious values. She may also believe that violence is normal, justified and controllable; these beliefs are more common in women who grew up in abusive homes.

The victim may also have a cognitive defense style of learned helplessness, as originally described by Seligman (1975) to explain depression. When a person has experienced trauma she cannot control, her motivation to respond in the face of later trauma is diminished. In spouse abuse, a learned helplessness stance is developed partially due to the attacks being unprovoked, without cues, and of a degree not corresponding to the external events (Martin, 1976). In addition, when women do act to help themselves, their efforts may not be rewarded in the external world. For instance, physicians do not ask about possible abuse and the legal system does not respond by issuing assault charges when women request them (only 3% of women were successful in this endeavor). Then, the women may be punished when their attempts to protect themselves threaten the husband and she may be subjected to additional abuse (Follingstad, 1980)

Another negative coping mechanism important to mention involves the displacement of anger; some battered women abuse their children physically. Inquiry into this dynamic is crucial, as the physician is often able to convince a woman that treatment is imperative if her children are at risk, either due to her bouts of anger or the abuse of her partner.

Initial Interventions and Counseling Approach

After the physician has determined that the patient is a victim of abuse: (a) they should attempt to

assess the level of current danger; (b) develop an atmosphere of empathy and understanding and counsel her about her experiences; (c) validate her fears and negative emotions; (d) discuss immediate and long-range alternatives to living with violence; and (e) develop an appropriate intervention plan with the patient. "The battered woman should not be blamed for staying with the abusive partner, rather she must be understood as a victim/survivor. Yet, after the understanding must come the interventions to help her understand and confront the ties that bind" (Follingstad, et al, 1984, p 387).

The physician must help the patient to develop realistic expectations about leaving an abusive relationship. It is especially important for the physician to account for the factors that prompt women to stay and realize that expecting the patient to move immediately to a shelter and extricate herself from a dangerous situation is often not realistic. She should be sensitively counseled about the reasons that she has chosen not to leave before now, have the reasons validated as understandable and urged to develop a plan that will eventually be successful. In the meanwhile, she should be given emergency numbers (police, domestic crisis lines, women and children's shelters) and brought back for regular visits. In addition to leaving the relationship, intensive individual and conjoint counseling can be utilized in selected couples to overcome the cycle of violence in which they both live. These feelings deserve empathy on the part of the health care provider and skilled counseling to allow the woman to develop priorities that are more self-protective.

Various protocols have been proposed to deal with the presentation of abused women in the medical system (McLeer & Anwar, 1987). The plan that the physician develops depends partially on the level of risk to the patient's health/life that the situation encompasses. It is an interesting cultural phenomenon that we have legislation in place that allows the provider to involuntarily hospitalize someone who is suicidal or homicidal; yet the standard of care in emergency rooms is to send abused women home to an environment where their life is endangered. It is this standard of care which must be changed to better prevent recurrence of the violence. For a situation deemed to present a high level risk, the physician should arrange for a shelter representative to meet the patient at the office or emergency room. Ask the patient to at least talk to the representative, even if she appears intent on going home. If there has been a clear assault on an adult only, ask woman for permission to call police or inform her of your plan to do so

Immediate intervention is required if children have also been abused. Physical abuse of children occurs in at least 40% of homes in which the man batters his partner. In the case of physical child abuse, the physician must notify the child protection team or another HRS agency of abuse. Inform the woman that this is mandatory and have her take steps to protect herself and the children during the investigation.

If your assessment indicates that the patient or others are at a moderate to low level risk: (a) provide her with the number of the local women and children's shelter; (b) provide her with the number and address of family counseling services and encourage participation by the woman and her partner; (c) Clarify her "point of contact" within the legal system, both police or sheriff's office and an attorney who could help her with a restraining order; (d) tell the patient that you are not only concerned for her safety, but that of the children; women may be motivated to seek help "for the sake of the children;" (e) provide her with a referral to vocational counseling or job information if she is unemployed or underemployed; and (f) have the patient return within two weeks for a re-check to re-assess the level of danger and her coping strategies.

Description of Effective Therapy Approaches: Informing Patients About What to Expect

Both individual and conjoint therapy are employed to treat couples with a history of domestic violence. For the conjoint therapy, co-therapy with opposite gender therapists is seen as the most effective therapeutic modality. "This technique diffuses anger, increases clarification, and helps reduce tensions or resentments that build into violence later." (Harris, 1986) During the initial stages of therapy, the couple should be separated and living apart, as this de-escalates the conflict and increases the motivation for the batterer to work on the relationship. Often, group treatment of male abusers is an essential part of treatment, as well as concurrent treatment for alcohol or drug abuse, when indicated. Individual and group treatment of abused women focuses on self-esteem, on the cultural determinants of violence, on appropriate assertiveness, and on direct treatment of depression and PTSD symptoms.

Counseling with couples involved in domestic violence has several key ingredients: (1) emphasizing the role of anger control, (2) teaching constructive problem-solving skills, (3) using behaviorally-oriented communication skills, (4) clarifying assumptions each party makes about the other's behaviors, (5) educating clients about the cycle of violence and asking for acceptance of appropriate responsibility around the violence from each partner, (6) educating clients in the use of time-outs and other anger-defusing techniques, (7) encouraging independence from the destructive parts of the relationship, and (8) teaching appropriate assertiveness skills.

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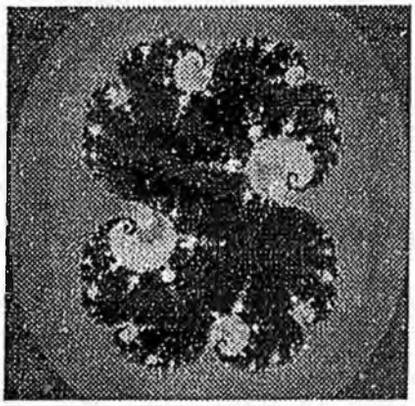
WHATS NEW
PUZZLES
TECHNIQUES
SCIENCE
INSPIRATION
HUMOR
SAMPLES
CORPORATE
PURPOSE
ATTRIBUTES
ORDER
LINKS

Enchanted Mind©

Creative Chaos



"Chaos is not merely a mindless jiggling, it's a subtle form of order."

What does chaos theory have to do with creativity? Everything. A simple understanding of chaos will forever change your idea of what creativity is all about. In truth there is no chaos, just different levels of order, interlaced and folding in upon itself.

The essential concepts behind chaos theory are that:

- **Perspective is the key to perceiving order.**
- **There is order in apparent randomness.**
- **It only takes a very small change to render a system chaotic, or conversely bring order to chaos. This event has been dubbed the "strange attractor".**
- **The strange attractor is self-reflective and redundant.**
- **Nature is composed of mirroring echoes of non-linear events.**

Perspective

The discernment between chaos and order is merely a point of view. "Maps are imaginative pictures which allow thought to bring into focus aspects of reality that might otherwise be lost in details. With a good map we can appreciate some features of a reality we could otherwise miss, and we can explore this reality in a way that would be actually impossible without the map." So say John Briggs and F. David Peat in their excellent book *Turbulent Mirror.*

If you are inside of something, say an atom, you only see electrons whirling chaotically around you. If you moved outside the atom you would see those electrons moving with a pattern around the atom. If you rise further above you see that atoms are actually the building blocks of larger structures called molecules. And so it goes, on up the scale, ad infinitum. The ever familiar 'forest from the trees' syndrome. It's all a matter of perspective. True creativity is allowing yourself to gain the loftiest perspective you can in relation to the object of your quandary or inquiry.

Order in Randomness

Creativity in its most meaningful sense renders order out of chaos. True creativity engenders new coherent form from existing patterns or ideas. The creative mind is not subdued by the apparent

coherent form from existing patterns or ideas. The creative mind is not subdued by the apparent anarchy of random chaos.

Chaos theory has discovered that when a system begins to veer out of balance, it is pulled in the new direction by a 'strange attractor.' According to John Briggs, "An attractor is a region of phase space which exerts a "magnetic" appeal for a system, seemingly pulling the system towards it."

The strange attractor is the force that pulls any system in an entirely new direction. When you focus on a solution to a puzzle, your focus is what pulls all the relevant information together to find the solution. In effect, concentrated focus is the strange attractor we use to manipulate the world in a way that is creative and purposeful.

Minimal Change

For a system to move out of a state of coherency, or order, it only takes a very small, self-replicating event to pull it into apparent chaos. Mathematicians found that it was a very small fractional interjection, multiplied upon itself, that sends a system into a new non-linear, seemingly chaotic direction. Chaos theory has also discovered that all things are interconnected. As the Taoist has always known, a butterfly in Asia exercising its wings can create a cyclone on the other side of the planet. Now we know why.

Fractals

These fractional changes in direction result in fractals. "Randomness, is interleaved with order, simplicity enfolds complexity, complexity harbors simplicity and order and chaos can be repeated at smaller and smaller scales, a phenomenon known as fractal." Fractals were so named because they are the very small change in events that folding in upon themselves can create whole new systems. Fractals are nested self-replicating events. A Chinese box of nested boxes is analogous to a fractal.

Redundant Echoes

Creativity takes all that has come before, ventures a bit further into the unknown, brings back the unknown and marries it to what is known. Sounds a bit like evolution doesn't it? It is the self-referential nature of chaos that moves it towards eventual order. Sacred geometry has shown us that nature is ever resplendent with self-replicating forms. The golden mean and the fibonacci series are evidence of this ever-repeating pattern. The fibonacci series continues to add unto itself as it increases. 1, 2, 3, 5, 8, 13.... Each number adds to the number before it as the progression continues. This is how nature adds back unto itself as it unfolds its myriad of forms. The asymmetry that is created from this process results in the golden mean, or the ratio of 1 : 1.6.

In summary, natural order is maintained by an mirroring feedback loop. We learn, and then add this learning to everything else we know. A creative mind seeks to appreciate the order within all things, and to create new form or systems from that existence order. A creative mind understands that chaos is relative to a point of view.

Possibly the best news coming out of chaos theory is that everyone does has an effect on the whole. Every contribution you make in a creative vein does have an effect on all that exists. There are no

small or meaningless creative acts.

Contemplation is the process by which creativity is generated. Thus, the true act of creativity is an act of self-reflection. Order is created from the mirroring of consciousness back onto itself. Venturing into the unknown, or venturing slightly off the beaten path, is the creative urge. Adding the new territory to the existing map is what allows the new effort and energy to take form.

Anyone interested in increasing their creative talents would be wise to read the *Turbulent Mirror* to gain a fuller understanding of this theory. Another book worth reading is *Order Out Of Chaos* by Ilya Prigogine and Isabelle Stengers. And, there is the book *Chaos* by James Gleick. Once you understand the profound implications that science is now revealing, your creative horizons will be infinitely broader. Once you understand how important you and what you do are in the whole scheme of things, you will fully appreciate the precious gift of creativity you hold.

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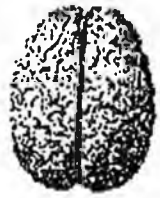
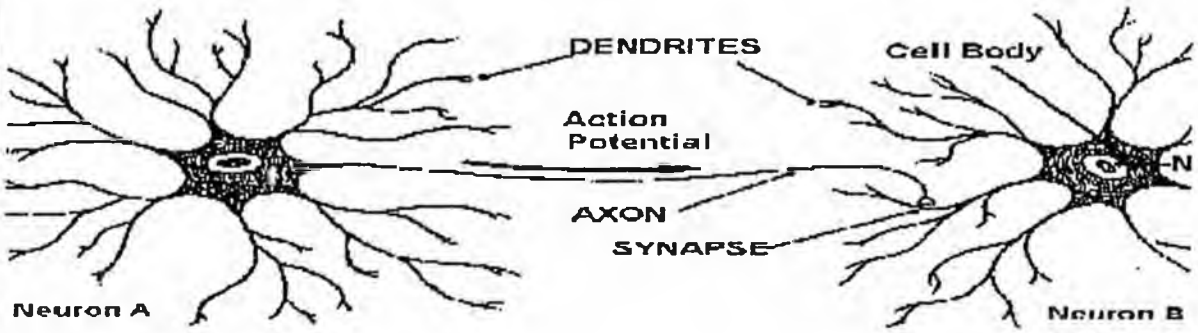
The Quantum Mechanical Brain and Creativity



We create our reality moment to moment. Noted physicists and mathematicians, as well as psychiatrists and neurophysiologists, are now supporting this opinion. Quantum mechanics supports the theory that personal creativity plays an essential role in our perception of the what we call reality.

MECHANICS OF NEURONAL FIRING

When a perception of any kind takes place an electrical impulse is sent from the senses to appropriate neurons in the brain. This impulse is carried along the axon out to the dendrites. Between each of the billions of dendrite connections within our brains there are little gaps. These gaps, called synapses, are microscopic in size. Communication takes place between these synapses through the use of neuro-transmitters.



Quantum physics has determined that wave patterns are the essential building blocks of the brain's electro-chemical neuro-transmitters. It is at the synapse that quantum wave patterns are transformed into neuro-transmitters. Through this neuronal synaptic firing the translated wave frequenies are made coherent. These coherent frequencies are then transferred from dendrite to dendrite to the appropriate areas of the brain.

Psychologist William Greenough conducted studies on rats in isolation as well as in stimulating environments. Upon examining their brains he discovered that the rats in the stimulated environment had more dendrite extensions, thus were richer in synaptic connections. It could be concluded, therefore, that a stimulated brain is able to process more information because it is richer in synaptic connectivity.

WE CANNOT PERCEIVE WHAT WE CANNOT CONCEIVE

We can only perceive, or literally see, what we can conceive of. We must have neuronal firing in our brains, whether it be in the imaginal state or actual perceptual state, for us to register an object as a reality.

Joseph Chilton Pearce's book "The Crack in the Cosmic Egg" purports and shows many examples that we can only perceive what we can conceive of. When Magellan's fleet sailed around the tip of South America he stopped at a placed called Tierra del Fuego. Coming ashore he met some local natives who had come out to see the strange visitors. The ship's historian documented that when Magellan came ashore the natives asked him how he had arrived. Magellan pointed out to his full-masted sailing ships at anchor off the coast. None of the natives could see the ships. Because they had never seen ships before they had no reference point for them in their brains, and could literally not see them with their eyes. Therefore, it is to our advantage to expose our brains to varied stimulus so that the proper neuronal connections are forged. In this way we expand and enrich our ability to experience more of our environment in a meaningful way.

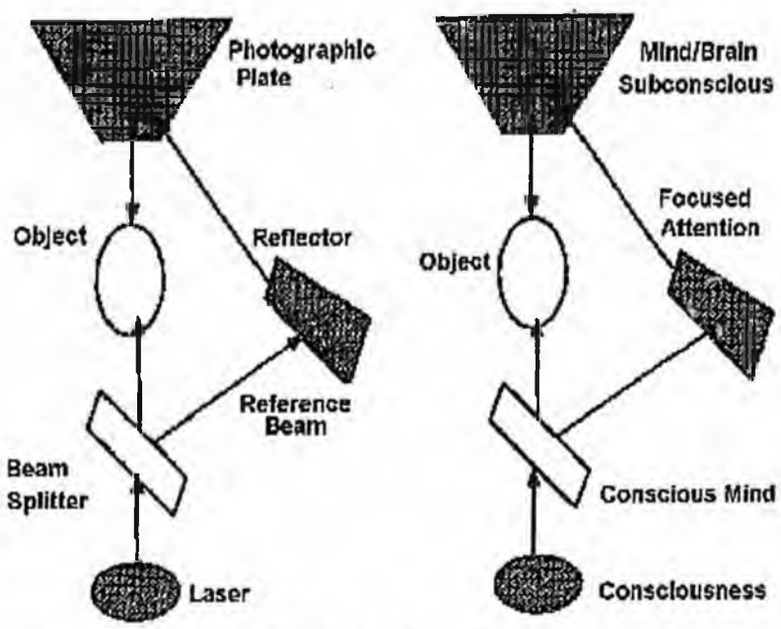
CODED WAVE INFORMATION

The brain translates consciousness, as coded wave patterns, into the coherent state we call mind. How does the brain form reality from these wave/particles, or interference pattern codes? Deepak Chopra in "Quantum Healing" gives us an example of the difference between interference patterns and a cohesive image. He says, "A good image for this would be a pianist playing a Chopin etude. Where is the music? You can find it at many levels - in the vibrating strings, the trip of the hammers, the fingers striking the keys, the black marks on the paper, or the nerve impulses produced in the player's brain. But all of these are just codes; the reality of music is the shimmering, beautiful, invisible form that haunts our memories without ever being present in the physical world."

This is similar to a computer that translates electric impulses of on and off signals. These impulses are translated into bits, the bits into bytes and the bytes into the patterns of language that produce a program. A stimulated brain is richer in synaptic potential, thus able to process more code. It is more like having a 32 bit Pentium as opposed to an 8 bit 286. Not only is the quantity of information processing greater, but with the capability of more sophisticated programming, or wave form transformation, the quality is also greater.

HOLOGRAPHIC MODEL OF CONSCIOUSNESS

Neurophysiologist, Karl Pribram has done extensive work to prove that the brain acts holographically to produce our experience of reality. Again, the brain is a transducer of interference wave patterns. It turns these wave frequencies into electrical and chemical patterns. A hologram is produced when a laser beam is split, bounced off of an object, and then reflected from a mirror onto a photographic plate. Another laser beam directed at the holographic plate produces a three dimensional hologram.



HOLOGRAM ON LEFT - CONSCIOUS MIND ON RIGHT

Our brain also converts and mirrors the interference patterns of the quantum world into three dimensional constructs. John Briggs and F. David Peat in "The Looking Glass Universe" explain that, "If the world is composed of frequencies and the brain is a frequency analyzer (itself made out of frequencies of matter), how does the three dimensional solid world we know come into being? The answer is as before: We have to learn it. We learn to respond mainly to certain frequencies and not to the constant transformations of frequencies. A few selected holograms become stabilized and apparently separate from one another into "things." The holograms, formed as memory, reinforce the impression of these separate things, and so the explicate space-time world we know evolves out of the implicate universe of waves and frequencies."

CONSCIOUSNESS AS A SUPERCONDUCTOR

A superconductor acts as a totally coherent medium which offers no resistance to whatever passes through it. A correlation between this superconductive state and consciousness itself is in "The Philosopher's Stone, Chaos, Synchronicity and the Hidden Order of the World" by F. David Peat. He explains, "One of the pioneering ideas about the brain is that it is a coherent quantum system, an idea that goes straight back to Herbert Froehlich. Consciousness, they argue, is all one piece; it is coherent and cannot be reduced to any classical mechanistic model. Just as the electrons in a superconductor engage in a global dance in which each individual movement is guided by the whole, so, too, individual activities of nerve cells may be coordinated into a much wider dance of thought."

CONCLUSION

The brain transforms the quantum wave patterns of consciousness into electro-chemical neuro-transmitters. This information is further translated in different parts of the brain holographically into what we call reality. The more you challenge your brain, the more connections you are going to form in the sea of neurons, axons and dendrites that translate waves of thought into a meaningful understanding of our world. Neurologists call this "use dependent plasticity." If you haven't forged a neural pathway that allows for a solution to an apparently

impossible problem, you can't intuit or recognize the answer, even when consciousness inspires you to see it. You can only see what you have allowed yourself to experience.

Use your brain, both sides of it. Map and mine those unexplored areas. Stretch it beyond it's familiar limits. Doing the daily puzzles presented here will challenge your notions of rational and non-rational thought. In attempting to solve the puzzles you are forging new neural pathways and enriching the number of synaptic clefts. You are overlaying habitual thinking processes with new potentials. You also entrain the brain as you search for solutions to certain kinds of lateral and analogical puzzles.

This is the stuff that genius is made of. Creative genius has an open mind and has pondered what other people don't dare to think about. In this way they are utilizing that 90% of the brain that science tells us now lies dormant. Ask yourself questions that don't have obvious answers. Allow yourself to contemplate those puzzling situations you would otherwise ignore. Everyone has creative potential as yet unrealized. Discover yours and be richer for it.

Related Reading Material

The Quantum Self by Danah Zohar
The Philosopher's Stone by F. David Peat
The Emperor's New Mind by Roger Penrose
The Holographic Universe by Michael Talbot
Quantum Healing by Deepak Chopra
Brain States by Tom Kenyon
The Three Pound Universe by Judith Hooper and Dick Teresi
The Amazing Brain by Robert Ornstein and Richard F. Thompson
Looking Glass Universe by John P. Briggs and F. David Peat

For a glance at the sample of puzzles that will be sent out each week see Samples.
More Research: Brain Plasticity, Build a Better Brain

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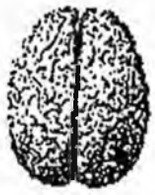
Building a Better Brain



Life magazine, July 1994 page 62.
By Daniel Golden and Alexander Tsiaras

Editor's Note: This is an excerpt from an article in Life magazine pointing to the research being done on ways to stimulate and increase brain power into old age. This is the article that was the original impetus for creating this web site. - Webmaster J. L. Read

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Evidence is accumulating that the brain works a lot like a muscle -- the harder you use it, the more it grows. Although scientists had long believed the brain's circuitry was hard-wired by adolescence and inflexible in adulthood, its newly discovered ability to change and adapt is apparently with us well into old age. Best of all, this research has opened up an exciting world of possibilities for treating strokes and head injuries -- and warding off Alzheimer's disease.

The party last year was as rowdy as it gets in a convent. Celebrating her 100th birthday, Sister Regina Mergens discarded her habit in favor of a daring red gown, downed two glasses of champagne and proclaimed her intention to live to 102. She didn't quite make it. Now, at vespers on a March afternoon in Mankato, MN, dozens of nuns file past the open casket where Mergens, 101 lies, rosary beads in her hands.

Concealed from view is an incision in the back of Mergen's head through which her brain has been removed. Mergens and nearly 700 elderly sisters in her order are the largest group of brain donors in the world. By examining these nuns, as well as thousands of stroke victims, amputees and people with brain injuries, researchers are living up to the promise of a presidential proclamation that the 1990s be the Decade of the Brain. Scientists are beginning to understand that the brain has a remarkable capacity to change and grow, even into old age, and that individuals have some control over how healthy and alert their brains remain as the years go by. The Sisters of Mankato, for example, lead an intellectually challenging life, and recent research suggests that stimulating the mind with mental exercise may cause brain cells, called neurons, to branch wildly. The branching causes millions of additional connections, or synapses, between brain cells. Think of it, says Arnold Scheibel, director of UCLA's Brain Research Institute, as a computer with a bigger memory board: "You can do more things more quickly."

The capacity of the brain to change offers a new hope for preventing and treating brain diseases. It helps explain why some people can:

- **Delay the onset of Alzheimer's disease symptoms for years. Studies show that the more**

Delay the onset of Alzheimer's disease symptoms for years. Studies show that the more educated a person is, the less likely he or she is to show symptoms of the disease. The reason: Intellectual activity develops brain tissue that compensates for tissue damaged by the disease.

- Make a better recovery from strokes. Research indicates that even when areas of the brain are permanently damaged by stroke, new message routes can be created to get around the roadblock or to resume the function of that area.

New knowledge about the brain may emerge from the obscure convent in Minnesota, a place where Ponce de Leon might have been tempted to test the waters. Mankato is the site of the northwest headquarters of the School Sisters of Notre Dame, where a long life is normal. In part because the nuns of this order don't drink much, smoke or die in childbirth, they live to an average age of 85, and many live far beyond that. Of the 150 retired nuns residing in this real-life Cocoon, 25 are older than 90.

But longevity is only part of the nuns' story. They also do not seem to suffer from dementia, Alzheimer's and other debilitating brain diseases as early or as severely as the general population. David Snowdon of the Sander's Brown Center on Aging at the University of Kentucky, the professor of preventative medicine who has been studying the nuns for several years, had found that those who earn college degrees, who teach, who constantly challenge their minds, live longer than less-educated nuns who clean rooms or work in the kitchen. He suspects the difference lies in how they use their heads.

Within the human brain each neuron contains at one end threadlike appendages called axons, which send signals to other nearby neurons. At the other end of the neuron are similar threadlike appendages called dendrites, which receive messages from nearby cells. Axons and dendrites tend to shrink with age, but experiments with rats have shown that intellectual exertion can spur neurons to branch like the roots of a growing tree, creating networks of new connections. Once a skill becomes automatic, the extra connections may fade, but the brain is so plastic that they can be tapped again if needed. Like the power grid of an electric company, the branching and connections provide surplus capacity in a brownout. Snowdon and some neuroscientists believe that people with such surplus who find their normal neural pathways blocked by the tangles that characterize Alzheimer's disease can reroute messages. To be sure, every brain is limited by genetic endowment, and flexibility does decrease with age. But new thinking in brain science suggests that whether someone hits that wall at age 65 or at age 102 may be partly up the the individual.

Professor Snowdon says the nuns of Mankato demonstrate this. He expects to prove that the better-educated sisters have significantly more cortex and more synaptic branching of neurons than their less-educated counterparts, which would allow the former to cope better with Alzheimer's disease, dementia and stroke. Brain exercising is a way of life at the nunnery, where the sisters live by the principle that an idle mind is the devil's plaything. They write spiritual meditations in their journals and letters to their congressmen about the blockade in Haiti, and do puzzles of all sorts....One 99 year-old, Sister Mary Esther Boor, takes advantage of slow minutes while working as the complex's receptionist to solve brainteasers -- some with words in Spanish.

What can the average person do to strengthen his or her mind? The important thing is to be actively involved in areas unfamiliar to you, says Steel, head of UCLA's Brain Research Institute. "Anything that's intellectually challenging can probably serve as a kind of stimulus for dendritic growth, which means it adds to the computational reserve in your brain."

So pick something that's diverting and, more important, unfamiliar. A computer programmer might try sculpture, a ballerina might try marine navigation. Here are some other stimulating suggestions from brain researchers:

"Do puzzles, I can't stand crosswords," says neuroscientist Antonio Damasio of the University of Iowa, "but they're a good idea." Psychologist Sherry Willis of Pennsylvania State University says, "People who do jigsaw puzzles show greater spatial ability, which you use when you look at a map."

And remember, researchers agree that it's never too late. Says Scheibel: "All of life should be a learning experience, not just for the trivial reasons but because by continuing the learning process, we are challenging our brain and therefore building brain circuitry. Literally. This is the way the brain operates."

This article also discusses the enigma of phantom limbs and how the brain continues to register impulses due to synaptic connectivity long after the limb itself is gone. If you are interested you can probably pick up a copy of this article at any library. The pictures are excellent and this is information that everyone should be aware of.

More Research: Brain Plasticity

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INCUBATED IN TERROR:

Neurodevelopmental Factors in the 'Cycle of Violence'

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"Children are not resilient, children are malleable."

RESILIENT

1. Marked by the ability to recover readily, as from misfortune.
2. Capable of *returning to an original shape or position*, as after having been compressed.

MALLEABLE

1. *Capable of being shaped or formed*, as by hammering or pressure: a malleable metal.
2. Easily controlled or influenced; tractable.
3. Able to adjust to changing circumstances; adaptable.

Approximately 250,000 years ago, a few thousand *Homo sapiens* (our first genetically-equivalent ancestors) migrated out of Africa, beginning the long transgenerational process of inhabiting and, ultimately, dominating of the rest of the natural world (Leakey, 1994). This fragile process was aided by a great deal of luck and the remarkable potential of the human brain to allow non-genetic, transgenerational transmission of information (sociocultural evolution). For thousands of generations, life was characterized by danger -- omnipresent threat and pervasive intra- and interspecies violence. Humankind and our current sociocultural practices evolved in -- and, therefore, reflect -- a brutal, violent and unpredictable world. The evolution of complex cultures and 'civilization' have not protected millions from

the brutality which characterized the 'ascent' of humankind. While 'civilization' has decreased our vulnerability to non-human predators, it has done little to decrease intraspecies violence (Keegan, 1993). Indeed, modern history is characterized by increasingly efficient, systematic and institutionalized violence (e.g., the Inquisition, slavery, the Holocaust, the Trail of Tears). Men were, and men remain, the major predators of vulnerable humans (typically women and children). The profound impact of domestic violence, community violence, physical and sexual abuse and other forms of predatory or impulsive assault can not be overestimated. Violence impacts the victims, the witnesses -- and, ultimately, us all. Understanding and modifying our violent nature will determine, in large part, the degree to which we will successfully 'adapt' to the challenges of the future -- the degree to which future generations of human beings can actually experience humanity.

In order to understand the origins and impact of interpersonal violence, it is essential to appreciate how violence alters the developing child. The child and the adult reflect the world they are raised in. And, sadly, in today's world, millions of children are raised in unstable and violent settings. Literally, incubated in terror.

In the United States alone, at least 5 million children are victims of and/or witnesses to physical abuse, domestic violence or community violence -- all while they are bathed in the powerful images of television which over-represent violent acts and over-value the viability of violence as a solution to conflict (Perry, 1994a; Prothrow-Stith, 1991; Dodge et al., 1991; Osofsky, 1995). What is the impact of these pervasive experiences with violence on the developing child ? How does violence change the child ? What is the impact of being repeatedly assaulted by a parent -- how is that different from being targeted in a drive-by shooting or watching a loved one being assaulted or watching a 'pretend', but graphic, murder on television ? How do these childhood experiences contribute to the much-discussed but little-understood 'cycle of violence' ?

This chapter will examine these questions in context of neurodevelopment -- how these experiences influence brain development and subsequent emotional, behavioral, cognitive and social functioning of children. The amazing capacity of the human brain to develop in a 'use-dependent' fashion -- growing, organizing and functioning in response to developmental experience -- means that the major modifier of all human behavior is experience. Experience, not genetics, results in the critical neurobiological factors associated with violence. A common error in examining the 'neurobiology' of violence is to presume a neurobiological trait, a biochemical marker (e.g., whole blood serotonin, or CSF 5-HIAA), which may be altered in 'violent' populations suggests a genetic difference. Nothing could be further from the truth.

There is no more specific 'biological' determinant than a relationship. Human beings evolved as social animals and the majority of biology of the brain is dedicated to mediating the complex interactions required to keep small, naked, weak, individual humans alive by being part of a larger biological whole -- the family, the clan. Indeed, it is the primary caretaking relationships of infancy and childhood which determine the core neurobiological organization of the human individual, thereby allowing this incredible social specialization. Early life experience determines core neurobiology. The experiences which will be the focus of this chapter include those which predispose to violent behavior and those which result from exposure to violent behavior. The two are inextricably intertwined.

VIOLENCE and the DEVELOPING BRAIN

Violence is heterogeneous -- in etiology, quality, quantity and impact on its victims. Physical violence can be the result of impulsive, reactive behavior or predatory, remorseless aggression. Physical violence can be related to intoxication from alcohol or from psychosis or from other neuropsychiatric conditions (e.g., dementia, traumatic head injury). Physical violence may be the result of a personal (Oklahoma City

bombing) or a cultural (political terrorism) belief system. Physical violence can be sexualized (rape) or directed at a specific victim (domestic violence) or at a specific group (e.g., African-Americans, homosexuals, Jews). Violence may be physical or emotional. Indeed, some of the most destructive violence does not break bones, it breaks minds (Vachss, 1994). Emotional violence does not result in the death of the body, it results in death of the soul.

The major setting for violence in America is the home (Straus, 1974). Intrafamilial abuse, neglect and domestic battery account for the majority of physical and emotional violence suffered by children in this country (see Koop et al., 1992; Horowitz et al., 1995; Carnegie Council on Adolescent Development, 1995). Despite this, a majority of our entertainment, media and public policy efforts focus on community or predatory violence. Understanding the roots of community and predatory violence is impossible unless the effects of intrafamilial violence, abuse and neglect on the development of the child are examined. Indeed, the adolescents and adults responsible for community and predatory violence likely developed the emotional, behavioral, cognitive and physiological characteristics which mediate these violent behaviors as a result of intrafamilial violence during childhood (O'Keefe, 1995; Myers et al., 1995; Mones, 1991; Hickey, 1991; Loeber et al., 1993; Lewis et al., 1989).

What are the pathways from terrorized infant to terrorizing adolescent ? How can someone develop the capacity to stalk, torture, murder and mutilate another human being and feel no remorse -- even feel pleasure ? How can a 14 year old kill someone over a jacket ? How can someone load a truck with explosives and blow up a building full of anonymous and innocent people ? How can someone beat senseless the woman they 'love' and, if she leaves, taking the children, track them down and kill them all ? Why are men so much more violent than women ? What happens to people to make them act like "animals" ?

All violent behavior impacts the children in its wake, but there is heterogeneity of impact. Important factors in the differential impact on the developing child include the type of violence, the pattern of violence, the presence (or absence) of supportive adult caretakers and other support systems, and, of key importance, the age of the child (for review see Pynoos, 1990; Schwarz and Perry, 1994). Under all circumstances, however, the organ which allows the child victim to adapt to any violent trauma is the brain -- just as the brain is the organ that is the origin for the violent behaviors of the victimizer. How is it that the very neurobiological adaptations which allow the child to survive violence may, as the child grows older, result in an increased tendency to be violent ? It is not the finger pulling the trigger that kills; it is not the penis that rapes -- it is the brain. In order to understand violence we need to understand the organization and functioning of its birthplace -- the brain.

Brain Organization and Function

The human brain is an amazing organ which acts to sense, process, perceive, store and act on information from outside and inside the body all solely to promote survival. In order to carry out these functions, the human brain has evolved a highly functional hierarchical organization -- from the lower, more simple portions to the more complex higher cortical regions (Figure 1). Various functions are mediated by various brain areas -- with more simple, regulatory functions (e.g., regulation of respiration, heartrate, blood pressure, body temperature) mediated by the 'lower' parts of the brain (brainstem and midbrain) and the most complex functions (e.g., language and abstract thinking) by its most complex cortical structures. The hierarchy of increasingly complex functions is mediated by the hierarchy of increasingly complex brain areas (Figure 1).

The structural organization and functional capabilities of the mature brain develop throughout life, with the vast majority of the critical structural organization taking place in childhood. Brain development is

characterized by 1) sequential development and 'sensitivity' -- from the brainstem to the cortex -- and 2) 'use-dependent' organization of these various brain areas (see below). As the brain develops in this sequential and hierarchical fashion, as the more complex limbic, sub-cortical and cortical areas organize, they begin to modulate, moderate and 'control' the more primitive and 'reactive' lower portions of the brain (Figure 2). These various brain areas develop, organize and become fully functional at different stages during childhood (Singer, 1995). At birth, for example, the brainstem areas responsible for regulating cardiovascular and respiratory function must be intact while the cortical areas responsible for abstract cognition have years before they are required to be fully-functional. A frustrated three year old (with a relatively unorganized cortex) will have a difficult time modulating the reactive, brainstem-mediated state of arousal -- he will scream, kick, bite, throw and hit. However, the older child when frustrated may feel like kicking, biting and spitting, but has 'built in' the capacity to modulate and inhibit those urges. All theoretical frameworks in developmental psychology describe this sequential development of ego-functions and super-ego which are, simply, cortically-mediated, inhibitory capabilities which modulate the more primitive, less mature, reactive impulses of the human brain. Loss of cortical function through any variety of pathological process (e.g., stroke, dementia) results in 'regression' -- simply, a loss of cortical modulation of arousal, impulsivity, motor hyperactivity, and aggressivity -- all mediated by lower portions of the central nervous system (brainstem, midbrain). Conversely, any deprivation of optimal developmental experiences (which leads to underdevelopment of cortical, sub-cortical and limbic areas) will necessarily result in persistence of primitive, immature behavioral reactivity. And, thereby, predispose to violent behavior (see Figures 5 and 7).

Essential to understanding the neurobiology of violence is this: The brain's impulse-mediating capacity is related to the ratio between the excitatory activity of the lower, more-primitive portions of the brain and the modulating activity of higher, sub-cortical and cortical areas (Figure 3). Any factors which increase the activity or reactivity of the brainstem (e.g., chronic traumatic stress) or decrease the moderating capacity of the limbic or cortical areas (e.g., neglect, EtOH) will increase an individual's aggressivity, impulsivity and capacity to display violence (Halperin et al., 1995) see below). A key neurodevelopmental factor which plays a major role in determining this moderating capacity is the brain's amazing capacity to organize and change in a 'use-dependent' fashion.

In the developing brain, undifferentiated neural systems are critically dependent upon sets of environmental and micro-environmental cues (e.g., neurotransmitters, cellular adhesion molecules, neurohormones, amino acids, ions) in order for them to appropriately organize from their undifferentiated, immature forms (see Perry, 1994a; Perry et al., 1994b; Lauder, 1988). Lack (or disruption) of these critical cues can result in abnormal neuronal division, migration, differentiation, synaptogenesis -- all of which contribute to malorganization and diminished functional capabilities related to that portion of the brain (Perry, 1988; Perry, 1994a; Perry, 1995a). These molecular cues, in turn, are dependent upon the experiences of the developing child. The quantity, pattern of activity and nature of these neurochemical and neurotrophic factors depend upon the presence and the nature of the child's total sensory experience (e.g., Kandel, 1989; Goelet et al., 1986; Thoenen, 1995).

Different areas of the CNS are in the process of organization at different times. During these critical periods of primary neural system organization, the brain requires and is most sensitive to organizing experiences (and the neurotrophic cues related to these experiences). Disruptions of experience-dependent neurochemical signals during these periods may lead to major abnormalities or deficits in neurodevelopment -- some of which may not be reversible (see below). Disruption of critical cues can result from 1) lack of sensory experience during critical periods or 2) atypical or abnormal patterns of necessary cues due to extremes of experience. Due to the sequential development of the brain, disruptions of normal developmental processes early in life (e.g., during the perinatal period) which alter development of the brainstem or midbrain will necessarily alter the development of limbic and cortical

areas because critical signals these area depend on for normal organization originate in these lower brain areas (see Figure 4). The clear implication of this immutable neurophysiological chain of development is that, again, early life experiences have disproportionate importance in organizing the mature brain. Experiences which could be tolerated by a 12 year old child can literally destroy an infant (e.g., being untouched for two weeks). Both lack of critical nurturing experience and excess exposure to traumatic violence will alter the developing CNS, predisposing to a more impulsive, reactive and violent individual.

Emotional Neglect

A fifteen year old boy sees some fancy sneakers he wants. Another child is wearing them -- so he pulls out a gun and demands them. The younger child, at gunpoint, takes off his shoes and surrenders them. The fifteen year old puts the gun to the child's head, smiles and pulls the trigger. When he arrested, the officers are chilled by his apparent lack of remorse. Asked later whether, if he could turn back the clock, would he do anything differently, he thinks and replies, "I would have cleaned my shoes." 'His' bloody shoes led to his arrest. He exhibits regret for being caught, an intellectual, cognitive response. But remorse -- an affect -- is absent. He feels no connection to the pain of his victim. Neglected and humiliated by his primary caretakers when he was young, this fifteen year old murderer is, literally, emotionally retarded. The part of his brain which would have allowed him to feel connected to other human beings -- empathy -- simply did not develop. He has affective blindness. Just as the retarded child lacks the capacity to understand abstract cognitive concepts, this young murderer lacks the capacity to be connected to other human beings in a healthy way. Experience, or rather lack of critical experiences, resulted in this affective blindness -- this emotional retardation.

Very narrow windows - critical periods - exist during which specific sensory experience is required for optimal organization and development of any brain area (e.g., Singer, 1995; Thoenen, 1995). Absent such experience and development, dysfunction is inevitable (e.g., Carlson et al., 1989). When critical periods have been examined in great detail in non-human animals for the primary sensory modalities, similar use-dependent differentiation in development of the brain occurs for the rest of the central nervous system (Diamond et al., 1964; Altman et al., 1964; Cragg, 1967; Cragg, 1969; Cummins et al., 1979). Abnormal micro-environmental cues and atypical patterns of neural activity during critical and sensitive periods can result in malorganization and compromised function in other brain-mediated functions such as empathy, attachment and affect regulation (e.g., Green et al., 1981). Some of the most powerful clinical examples of this are related to lack of 'attachment' experiences early in life. The child who has been emotionally neglected or abandoned early in life will exhibit attachment problems which are persistently resistant to any 'replacement' experiences including therapy (Carlson et al., 1989; Ebinger, 1974). Examples of this include feral children, Spitz's orphans (Spitz et al., 1946), the Romanian orphans (Chisholm et al., 1995) and, sadly, the remorseless, violent child (Ressler et al., 1988; Myers et al., 1995; Mones, 1991; Hickey, 1991; Greenberg et al., 1993).

Lack of appropriate affective experience early in life and the resulting malorganization of attachment capabilities plays a major role in the current epidemic of senseless violence in the United States today(Lewis et al., 1989). So often, these acts are inhuman -- throwing a six year old boy out of a window because he refused to steal candy for you -- planning, stalking, kidnapping and torturing someone who 'disrespected' you -- hunting any homeless man to set on fire. *Senseless* --- or are they senseless acts ? The ability to feel remorse, to be empathetic, to be sympathetic -- are all experience-based capabilities. If a child feels no emotional attachment to any human being, then one cannot expect any more remorse from him after killing a human than one would expect from someone who ran over a squirrel. These behaviors are not senseless, they are not beyond our understanding. They arise from children reflecting the world in which they have been raised (Taylor et al., 1992; Perry, Pollard, Blakley, Baker, & Vigilante, in press).

It is important to emphasize that the majority of individuals who are emotionally neglected in childhood do not grow into violent individuals. These victims carry their scars in other ways, usually in a profound emptiness, or in emotionally destructive relationships, moving through life disconnected from others and robbed of some of their humanity. The effects of emotional neglect in childhood predispose to violence by decreasing the strength of the sub-cortical and cortical impulse-modulating capacity and by decreasing the value of other humans due to an incapacity to empathize or sympathize with them. This decreased value of humans means that there is a much lower threshold for the unattached person to act in an antisocial fashion to gratify their impulses.

Cognitive Neglect

There are other deprivations of experience which play a major role in impulsive and reactive violence. These are experiences which, in effect, 'feed' and grow the human cortex (Singer, 1995; Thoenen, 1995; Brown, 1994). As the cortex plays a major role in inhibiting, modulating and regulating the functioning of the lower parts of the central nervous system, any experiences which increase this cortical capacity would be expected to decrease violent behavior (Moffitt et al., 1988; MacEwen, 1994). The human cortex grows in size, develops complexity, makes synaptic connections and modifies as a function of the quality and quantity of sensory experience (Chisholm et al., 1995; Singer, 1995; Courchesne et al., 1994). Lack of type and quantity of sensory-motor and cognitive experiences leads to underdevelopment of the cortex (see Figure 5). The cortical and sub-cortical areas are smaller in individuals who have suffered global environmental neglect. In our preliminary studies, we have demonstrated 'cortical atrophy' (as read independently by neuroradiologists) in 7 of 12 severely neglected children (Pollard and Perry, submitted). These children (average age 8) did not develop cortical and subcortical structures which subsequently atrophied. These areas, which develop in a use-dependent fashion, were under-used, resulting in profound underdevelopment of these areas. There are multiple examples of the negative impact of environmental deprivation on the developing brain in animal studies. Rats raised in environmentally enriched setting have a 30% higher synaptic density in cortex than rats raised in an environmentally deprived setting (Bennett et al., 1964; Altman et al., 1964). Animals raised in the wild have from 15 to 30% larger brain mass than their offspring who are domestically reared (Darwin, 1868; Rehkamper et al., 1988; Rohrs, 1955).

A striking example of the role of cognitive development (development of a literate population) on violence comes from historical accounts of violence. In the year 1340 in Amsterdam, the murder rate was in excess of 150 murders per 100,000 people. Two hundred years later the murder rate was below 5 per 100,000 people. Clearly this is not a 'genetic' phenomenon. The genetics of the population of Amsterdam likely did not change much in two hundred years. This marked decrease in the incidence of murderous violence likely is due to the development of a higher percentage of individuals in that society having better developed cortices -- more capable of abstract cognition, and, thus, more capable of modulation of aggressive and violent impulses. The sociocultural phenomenon underlying the development of healthier and more capable cortices was, without question, literacy. The introduction of the printing press allowed the percentage of literate (i.e., cortically-enriched, cognitively-capable individuals) to dramatically increase. Over a few generations, the impact of a number of bright, abstract individuals transformed their society.

The introduction of television has had a similar revolutionary impact on the organization and functional capacity of the human brain (remember, the organization and functional capacity of the brain reflects the pattern and nature of sensory input during development). The implications of this major sociocultural and environmental phenomenon on development have yet to be fully realized. Ominous clues abound, however (Donnerstein et al., 1995). American children raised on Sesame Street and MTV are impatient with even moderately slow presentations of any stimuli, written, spoken, or visual (Carnegie Council on

Adolescent Development, 1995). The brain of a human infant born in 20,000 B.C. had the same potential as an infant born in 1995. Despite the fact that 22,000 years ago there was essentially little language, no science, no understanding of 'computers', if this pre-historic infant was raised today, she would be playing Nintendo, watching MTV, reading, writing and 'thinking' in as abstract a fashion as any child born today. The brains of our children are organized differently from ours. The increase in youth violence is related to the world we have provided for our children to grow up in (Wright et al., 1992; Taylor et al., 1992; Richters, 1993; Osofsky, 1995) -- a world markedly different from the one in which our brains developed.

Traumatic Violence: The Persisting State of Fear

Children exposed to chronic violence are more likely to be violent (e.g., Loeber et al., 1993; Lewis et al., 1989; Koop et al., 1992; Hickey, 1991; Halperin et al., 1995). This is related to many factors, including modeling and learning that violent aggression is acceptable, even a preferable and honorable, solution to problems. Analysis of much of the violent behavior by children and adolescents today reveals a troubling degree of impulsive, reactive violence. This violence is often interpreted by the perpetrators as defensive. "If I didn't shoot him, he would have shot me." "I could tell that he was going to jump me -- he looked me in the eyes." "Listen, man, I just did him before he did me. So. " These verbalizations reflect the persistence of a state of fear, literally, a persisting 'fight or flight' state which these adolescents are unable to get out of. The persistence of this originally adaptive internal state is due to growing up in a persistently threatening environment (Perry, 1994; Perry, 1996).

If during development, this stress response apparatus is required to be persistently active, a commesurate stress response apparatus in the central nervous system will develop in response to constant threat. These stress-response neural systems (and all functions they mediate) will be overactive and hypersensitive. It is highly adaptive for a child growing up in a violent, chaotic environment to be hypersensitive to external stimuli, to be hypervigilant, and to be in a persistent stress-response state (see Figure 6). In most cases, however, these "survival tactics" ill-serve the child when the environment changes.

Clinically, this is very easily observed in children who are exposed to chronic neurodevelopmental trauma (Perry, 1994a; Perry, 1995a). These children are frequently diagnosed as having attention deficit disorder (ADD-H) with hyperactivity (Haddad et al., 1992). This is somewhat misleading, however. It is not that they have a core abnormality of their capacity to attend to a given task, it is that they are hypervigilant. These children have behavioral impulsivity and cognitive distortions (Pynoos et al., 1985; Pynoos, 1990), all of which result from a use-dependent organization of the brain (Perry, Pollard, Blakley, Baker, & Vigilante, in press). During development, these children spent so much time in a low-level state of fear (mediated by brainstem and midbrain areas) that they were focusing consistently on non-verbal cues. In our clinical population, children raised in chronically traumatic environments a prominent V-P split on IQ testing (n = 108; WISC Verbal = 8.2; WISC Performance = 10.4, Perry, in preparation). This is consistent with the clinical observations of teachers that these children are really smart but can't learn easily. Often these children are labeled as learning disabled. These difficulties with cognitive organization contribute to a more primitive, less mature style of problem-solving -- with violence often being employed as a "tool". All of these symptoms are the result of a use-dependent organization of the brain stem nuclei involved in the stress response apparatus (Perry, 1988; Perry et al., 1994b).

These children are also characterized by persisting physiological hyperarousal and hyperactivity (Perry, 1995a; Perry, et al., in press). They are observed to have increased muscle tone, frequently a low grade increase in temperature, an increased startle response, profound sleep disturbances, affect regulation problems and generalized (or specific) anxiety (Kaufman, 1991; Ornitz et al., 1989; Perry, 1994a). In addition, our studies indicate that a significant portion of these children have abnormalities in cardiovascular regulation (Perry, 1994a; Perry et al., 1995b). Using continuous heartrate monitoring

during clinical interviews, male, pre-adolescent children exposed to violence exhibited a mild tachycardia during non-intrusive interview and a marked tachycardia during interviews about specific exposure to trauma (n = 83; resting heartrate = 104; interview heartrate = 122). In comparison, females exposed to traumatic events tended to have normal or mild tachycardia which, during interviews about the traumatic event decreased (n =24; resting heartrate = 98; interview heartrate = 82). This gender difference was associated by differences in emotional and behavioral symptoms, with males exhibiting more 'externalizing' and females more 'internalizing' symptoms (Perry, et al., 1995b; Perry, et al., in press;).

In our work with another population of boys exposed to severe prolonged domestic violence (n = 65) at a residential treatment center, a subset of the hyperaroused, reactive boys (n = 65 total; predatory subset = 12) developed predatory aggressive behaviors. In early adolescence, this subset of boys actually had a normalization of the tacycardia noted when they were younger. Indeed, they began exhibiting decreases in heartrate when asked to discuss specific violent events they had been involved in. Some of these youth described a soothing, calming feeling when they began 'stalking' a potential victim. The detached, calm, dissociated (and re-inforcing) feeling these boys felt is reminicent of the feelings described by borderline adolesent girls who cut themselves and may be related to an endogenous opioid release similar to that seen in various dissociative states (Perry, in preparation). These preliminary observations are consistent with recent reports of the physiological differences between a cohort of 15 year old antisocial youth followed to age 29. In the group which by age 29 had become criminal, resting heartrates were much lower than controls and the comparison antisocial cohort (Raine et al., 1995).

The implications of this for the violent youth are profound. First, any child exposed to chronic intrafamilial violence will develop a persisting fear-response. Because there are marked gender differences in this response (Perry et al., 1995b; Perry, Pollard, Blakley, Baker, & Vigilante, in press), with females more likely to dissociate and males more likely to display a classic "fight or flight" response, more males will develop the aggressive, impulsive, reactive and hyperactive symptom presentation. Males will more likely be violent (George et al., 1979). This can be explained, in part, by the persistence of this "fight or flight" state -- and by the profound cognitive distortions that accompany this neurodevelopmental state. A young man with these characteristics, then, will very easily misinterpret a behavior as threatening and will, being more reactive, respond in a more impulsive and violent fashion. Literally, using the original (childhood) adaptive "fight or flight" response in a new context but, now, later in life, in a maladaptive fashion.

Finally, this reactivity of response is profoundly exaggerated by the influence of alcohol or other drugs (Shupe, 1954; Lindqvist, 1986; Cordilla, 1985). Unfortunately, the emotional emptiness resulting from neglect can only be filled by the temporary pleasure that an exogenous euphoriant (e.g., heroin, cocaine) can provide. Similarly, a young man may find the only escape from the distress and pain caused by the anxiety of a persisting fear response is with alcohol. It is often the intoxicating agents that allow expression of the neurodevelopmentally-determined pre-disposition for violence (Figure 8).

Ideology of Aggression

There are multiple pathways to engaging in violent behavior (Wolfgang et al., 1967). Some are defensive, some are predatory, some are impulsive. All of these pathways, however, are facilitated by the individual practitioner's belief system (MacEwen, 1994; Burton et al., 1994). The majority of neglected children never become violent. The majority of traumatized children never become violent (e.g., Belmore et al., 1994). Even the majority of traumatized and neglected children do not become remorselessly violent. Belief systems, in the final analysis, are the major contributors to violence. Racism, sexism, misogyny, children as property, idealization of violent "heroes", cultural tolerance of child maltreatment, tribalism, jingoism, nationalism -- all unleash, facilitate, encourage, and nurture violent individuals. Without these

facilitating belief systems and modeling, neglected and abused children would carry their pain forward in less violent ways -- as silent, scarred, adult members of the vast army one commentator has termed the "Children of the Secret" (Vachss, 1991).

Extreme violence of the most heinous sort (organized, systematic and remorseless) is conducted by individuals, groups of individuals, and by governments with the blessing of various belief systems (for God and Country). Indeed, the current "Violence Prevention" initiatives are really not interested in preventing all violence. These programs are focused on random, unpredictable physical violence against 'us'. The pervasive community violence of the inner cities was of little concern to the public policy makers in government until it metastasized to other parts of our society. Widespread ignorance of the intimate relationships between cultural belief systems, childrearing practices and the development of violent behaviors will doom any attempts to truly understand, and prevent, violence (Dodge et al., 1991; Richters, 1993).

Malignant Combination of Experiences

The most dangerous among us have come to be this way because of a malignant combination of experiences -- lack of critical early life nurturing (Radke-Yarrow et al., 1995), chaotic and cognitively impoverished environments (Carlson et al., 1989), pervasive physical threat (O'Keefe, 1995), persisting fear (Schwab-Stone et al., 1995) and, finally, watching the strongest, most violent in the home get what he wants, and seeing the same aggressive violent use of power idealized on television (Miedzian, 1991) and at the movies (Figure 9). These violent offenders have been incubated in terror, waiting to be old enough to get "one of those guns", waiting to be the one who controls, the one who takes, the one who hits, the one who can "make the fear, not take the fear." Nowhere is this predatory food chain more evident than in juvenile justice settings where, too often, the youth is either victim or predator -- with no third option. Due to clear socio-cultural devolution in some segments of our communities, there are more and more undersocialized, traumatized children (Horowitz et al., 1995; Carnegie Council on Adolescent Development, 1995). These children get little cognitive stimulation -- the public schools are falling apart; their lives are devoid of emotional contact -- mom is a child herself and pregnant again; no predictability, structure or nurturing can be found out of the home -- the community has dissolved.

Clinical Implications

There are a variety of important clinical considerations when examining the interplay between developmental trauma and brain development. One of the most obvious is the developmental stage at which it occurs. What may be partially 'absorbable' at age 15 may be devastating at age 5. The younger someone is, the fewer defensive capabilities they have. As we get older, reasoning and cognitive capabilities facilitate adaptation.

The intensity and frequency of the trauma determines how, in a use-dependent fashion, the brain will internalize the traumatic event. The proximity to (and reality of) threat, the degree to which body integrity and life-threatening experiences take place, and the presence of protective factors all play some role in this. The presence of a strong supportive family network or a strong stable adult figure is critically important. Children exposed to violence benefit from the presence of a stable adult even outside the home (for review see Pynoos, 1990; Schwarz and Perry, 1994).

Predictability of threat is important in determining the impact of a trauma. Stress is much more tolerable when it is relatively predictable. Indeed, there are a number of behavioal features of traumatized children which initially appear to be very maladaptive but are in fact very highly adaptive. This is seen with behaviors which solicit or a promote either physical or sexually abuse. A child who has been a victim of

unpredictable sexual or physical abuse learns (consciously or unconsciously) that if this abuse is going to happen, it is far preferable to control when it happens. As a result, children who have been violently physically assaulted will frequently engage in provocative, aggressive behavior in an attempt to elicit a predictable response from their 'environment'. This behavior is often misinterpreted, and the school or foster placement will punish them severely (often following a restraint situation), thereby re-inforcing the child's view of the world -- adults are aggressive and solve problems using force. Our ineffective child protective, mental health and juvenile justice systems teach this lesson to children again and again -- until they are big enough, smart enough or violent enough to turn the tables.

Intervention strategies with the emotionally-empty violent youth must be different from those designed for purely impulsive, reactively violent youth. Heterogeneity of violence dictates heterogeneity of intervention. Effective implementation of intervention and prevention strategies, therefore, requires effective assessment of the emotional, behavioral, cognitive, social and physiological functioning of the individual child (Vachss et al., 1979). A 'boot camp' model may be very effective for some, and dreadfully ineffective for others. Therapeutic intervention based upon interpersonal relationships may be critical for rehabilitation of some, while they are a waste of resources for others.

State-dependent storage and state-dependent recall are critical issues to consider when focusing on the violent youth (Ungerleider, 1995; Maunsell, 1995). These powerful principles of neurophysiological functioning relate back to the way in which the brain internalizes new information -- in a use dependent fashion. The only parts of the brain which can change are those parts which are on -- those that are being used. So that when asleep, storage of information -- or recall of previously stored information from parts of the brain that are active only during waking hours is impossible. This state-dependence is very important in the clinical approach to the traumatized child. When a child is in a state of hyperarousal -- a persisting fear-state -- this child will not easily be taught complex cognitive information, i.e., if the cortex is not active, it will not store information. The child will be focusing on non-verbal cues -- body movements, facial expressions, tone of voice -- searching for threat- storing that information, not the words which accompany this. Only when significantly 'calmed' will these children benefit from 'words.' What we can expect children to have access to during these states of arousal is their 'catalogue' of previous experiences -- their non-verbal memories, many of which are characterized by unpredictability, threat, pain, assault. They will (re)act accordingly. It is the task of therapeutic interventions to begin to provide a set of consistent alternative memories based upon trial after trial of neutral or positive interaction. Unfortunately, our interventions frequently mistarget the needs of a given child.

Interventions which are based simply upon a cognitive, problem-solving approach to conflict resolution can not be easily generalized to a perceived-threat situation. When a child or adolescent sits quietly in a room with peers and can think through a situation, non-violent resolution comes more easily. This same child, however, when threatened will be in a different internal state. The fearful child's cognition and behavior is being mediated by more primitive parts of the brain -- she will be more reactive, reflexive and will have a very difficult time pulling cognitive solutions from her cortex. Experience-based conflict resolution models offer advantages over simple cognitive, classroom based programs. Imagine a soldier trying to effectively learn how to act in combat by sitting in class. The soldier could learn, on a cognitive level, what to do. In combat, however, finding and applying this 'book-learning' will be virtually impossible. And any mistakes could be fatal.

Public Policy Implications

Ultimate solution to the problems of violence -- whether from the remorseless predator or the reactive, impulsive youth -- is primary prevention. Our society is creating violent children and youth at a rate far faster than we could ever treat, rehabilitate or even lock away (Groves et al., 1993; Garbarino, 1993;

Sturrock et al., 1983; Richters, 1993). No single intervention strategy will solve these heterogeneous problems. No set of intervention strategies will solve these transgenerational problems. In order to solve the problems of violence, *we need to transform our culture.*

We need to change our childrearing practices, we need to change the malignant and destructive view that children are the property of their biological parents. Human beings evolved not as individuals, but as communities. Despite Western conceptualizations, the smallest functional biological unit of humankind is not the individual -- it is the clan. No individual, no single parent-child dyad, no nuclear family could survive alone. We survived and evolved as clans -- interdependent -- socially, emotionally and biologically. Children belong to the community, they are entrusted to parents. American society, and its communities, have have failed parents and children alike. We have not provided parents with the information and resources to optimize their children's potential and, when parents fail, we act too late and with impotence to protect and care for maltreated children (Kendall et al., 1995; Urquiza et al., 1994; Klee et al., 1987; McIntyre et al., 1986; Carnegie Council on Adolescent Development, 1995).

The true potential of the human brain is rarely, if ever, realized. The major expressor of that potential is experience. The most critical and formative experiences are those provided to the developing child in the incubator of the family and, optimally, by a vital, invested community. Past and present, our society dramatically undervalues its young, despite the claims that 'we love children'.

It is in the nature of humankind to be violent, but it may not be the nature of humankind. Without major transformation of our culture, without putting action behind our 'love' of children, we may never learn the truth.

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FIGURES

FIGURE 1. Hierarchy of Brain Function. The human brain is organized from the most simple (e.g., fewest cells: brainstem) to most complex (e.g., most cells and most synapses: frontal cortex). The various functions of the brain, from most simple and reflexive (e.g., regulation of body temperature) to most complex (e.g., abstract thought) are mediated in parallel with these various areas. These areas organize during development and change in the mature brain in a 'use-dependent' fashion. The more a certain neural system is activated, the more it will 'build in' this neural state -- creating an internal representation of the experience corresponding to this neural activation. This use-dependent capacity to make internal representations of the external or internal world is the basis for learning and memory.

FIGURE 2: Cortical Modulation: The capacity to moderate frustration, impulsivity, aggression and violent behavior is age-related. With a set of sufficient motor, sensory, emotional, cognitive and social experiences during infancy and childhood, the mature brain develops - in a use-dependent fashion -- a mature, humane capacity to tolerate frustration, contain impulsivity and channel aggressive urges.

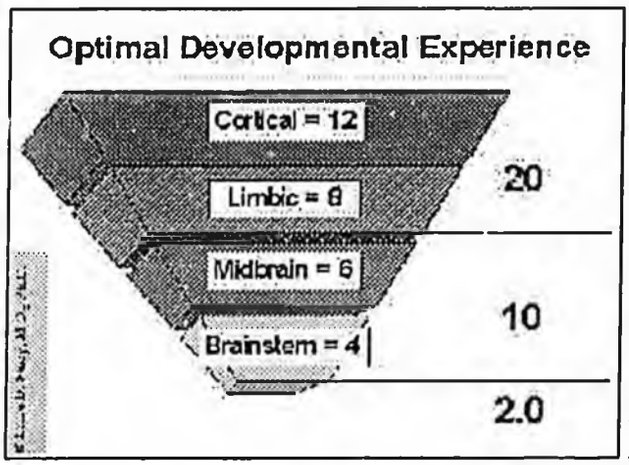

FIGURE 3. Ratio of Modulation: Optimal Development. A healthy Cortical Modulation ratio (Cortical and Limbic/Midbrain and Brainstem) develops when the child experiences a variety of optimal emotional, behavioral, cognitive and social experiences at key times during their development. This ratio indicates the relative 'power' of the maturing and mature brain to modulate the more primitive, reactive, reflexive output of the brainstem and midbrain. During infancy and childhood, sequential development of the brain necessitates that the lower, more primitive portions of the brain develop first and, over time, the output of these areas is shaped, modulated, modified in more mature fashion as the higher brain areas develop. Any disruption of development which either 'overdevelops' the midbrain and brainstem or 'under-develops' the limbic and cortical areas will result in an imbalance in the Cortical Modulation ratio, predisposing to aggressive and violent behavior.

FIGURE 4. Sequential Development of the Brain. The simple and unavoidable result of this sequential neurodevelopment is that the organizing, 'sensitive' brain of an infant or young children is more malleable to experience than a mature brain. While experience may alter and change the functioning of an adult, experience literally provides the organizing framework for an infant and child. The brain is most plastic (receptive to environmental input) in early childhood, therefore, the child is more vulnerable to variance of experience during this time.

FIGURE 5. Developmental Neglect: Emotional or Experiential Deprivation. The ability of the brain

to develop a healthy Cortical Modulation ratio (Cortical and Limbic/Midbrain and Brainstem) is impaired when key experiences are minimal or absent. This results in poor modulation of impulsivity, persisting 'primitive' or immature emotional and behavioral functioning and, in combination with other developmental experiences, a predisposition to violence. The ability of the maturing brain then, to modify impulsive and reactive responses in the face of stress or frustration is decreased in individuals deprived of specific developmental experiences.

FIGURE 6. The Persisting Fear Response: Developmental Trauma. A child raised in an environment characterized by persisting trauma (e.g., domestic violence, physical abuse, community violence) will develop an excessively active and reactive stress-response apparatus. The majority of the stress response systems reside in the brainstem and midbrain (e.g., locus coeruleus). Overdevelopment of these areas, even in the presence of optimal emotional or cognitive experience will result in an altered Cortical Modulation ratio and, a predisposition to act in an aggressive, impulsive, behaviorally reactive fashion.

FIGURE 7. Neglect and Trauma: The Malignant Combination. Developmental neglect or traumatic stress during childhood can profoundly alter development. Unfortunately, emotional and cognitive neglect usually occur in combination with traumatic stress. The combination of a lack of critical emotional experiences and persisting traumatic stress leads to a dramatic alteration in the brain's modulation and regulation capacity. This is characterized by an overdevelopment of brainstem and midbrain neurophysiology and functions (e.g., anxiety, impulsivity, poor affect regulation, motor hyperactivity) and an underdevelopment of limbic and cortical neurophysiology and functions (e.g., empathy, problem solving skills). This experience-based imbalance predisposes to a host of neuropsychiatric problems --. and, violent behavior.

FIGURE 8. Alcohol Decreases the Cortical Modulation Ratio. Upper Panel. Alcohol has a well-documented relationship to violent behavior. Under optimal circumstances, drinking can decrease judgment, impair capacity to modulate impulsivity and predispose to aggressive and violent behaviors. Alcohol does this, in part, because of mass action effects of the non-specific actions on neurons, decreasing functional capacity in all cells. Because the cortex has the most cells, however, it is relatively more sensitive to the non-specific effects of alcohol, resulting in the general phenomenon of 'getting' drunk from the top down. The sequence of loss of function under the influence of alcohol match the hierarchical sequence as illustrated in Fig. 1. The temporary decrease of Cortical Modulation ratio under the influence of alcohol leads to many violent actions.

Lower Panel: The capacity of alcohol to impair functioning and decrease Cortical Modulation ratio is even more dramatic in the poorly organized brain. The combination of alcohol (or other drugs) and a neglected, abused adolescent often leads to deadly and chilling violence.

FIGURE 9. Malignant Combination of Experience: Neurodevelopmental experiences of trauma or neglect alter a variety of brain areas and functions important in predisposing to violence. Depending upon the time in development, the nature (trauma, neglect or both) and extent of the abuse and the presence of attentuating factors, the developing brain will be impacted differentially. These experiences may occur in utero or in the perinatal period, impacting the brainstem and resulting in symptoms of anxiety. Experiences in the perinatal and first few years of life can impact the midbrain resulting in impulsive and aggressive symptoms. Trauma and neglect during infancy and childhood can impact the sub-cortical and limbic areas, resulting in dysthymic, depressed or unattached individuals. Finally, experiences throughout

childhood can impact the development of cognitive capabilities resulting in processing and problem-solving styles which predispose to violent solutions. Ultimately, however, being anxious or impulsive or depressed or unattached or cognitively-impaired do not compel violence by individuals. It is a malignant combination of one or more of these vulnerabilities in concert with a facilitating or encouraging belief system that leads to violent behaviors.

CIVITAS
INITIATIVE

The achievements and failures of any human living group-- family, clan, community-- reflect the transgenerational childrearing practices of its members. In the ways we care for our children, we create our society. We create the healers and the destroyers. Our children are reflections of the world in which we raise them. We reap what we sow.

In the United States, despite two centuries of extraordinary human achievement, our future is increasingly threatened by persisting ignorance about - and maltreatment of - children. Our policies and practices do not reflect an enduring understanding of the critical role that childrearing plays in the health and welfare of our world. This urgent issue underlies a myriad of personal, social, and economic problems threatening our future. We are in the midst of an invisible public health crisis - like a cancer growing, silently, in the heart of society.

Mission

CIVITAS Initiative catalyzes the development and distribution of practical, enduring solutions that promote the optimal development of children.

Research and programs which can address these problems already exist. Yet this information is inefficiently synthesized and transformed into practical knowledge, and rarely distributed for widespread impact. Innovative programs and policies are often isolated, under-funded, and - in a resource scarce world - competitive instead of cooperative. And the cancer spreads.

Discovery collects and distills research, programs and innovations in all aspects of child development, with a specific focus on maltreatment. Through information exchange and partnerships with individuals, agencies and institutions conducting effective work, CIVITAS Initiative continuously explores, evaluates and synthesizes working concepts from all disciplines affecting children.

Strategy
To do so, CIVITAS Initiative operates three integrated divisions - Discovery, Translation, and Communication.

Translation then incorporates these concepts and program elements into the CIVITAS Living Laboratories -- multi-institutional, public/private partnerships which integrate the innovations from many sites into comprehensive programs focused within a single community. In the Laboratories, ongoing research, training and clinical service delivery take place, with the goal of creating practical applications that can be exported and adapted to meet the specific needs and interests of other communities.

Communication uses media, technology and influential communicators to further infuse into the American consciousness those working concepts which support the optimal development of children. CIVITAS Initiative will create and manage the Cybrary™ of Child Development and Maltreatment, a comprehensive multimedia archive of translated, multi-disciplinary information on child development. Worldwide access to, and continuous promotion of, this knowledge can shift societal attitudes and behaviors regarding children and effect systemic changes which create the opportunities all children need to maximize their potential.

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Aggression and Violence:
The Neurobiology of Experience

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IN: The DevelopMentor

(AACAP)
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Each year in the United States alone, over 5 million children are directly exposed to violence. The most common form of destructive aggression takes place in the home in the form of physical abuse or domestic violence. The impact of these various forms of violence on children and adolescents is complex, but one result appears clear: the number of aggressive and violent youth is increasing dramatically. Young murderers (under age 18) in the United States tripled from 1984 to 1994. Currently 28,000 children and adolescents are known murderers. The number of violent crimes committed by youth is expected to double by the year 2010.

Are violent children conceived or created ? Is there a neurobiological reason that a child is violent ? What makes a child violent? Genes that make testosterone? Maternal neglect? Physical abuse? Modeling from a father hitting a mother? Impaired problem solving skills? Peer/gang pressures? Violence on television? Violent lyrics in music? Access to guns? In attempting to understand what makes a child violent, it is important to remember three points: 1) not all violence is the same, 2) the brain mediates all human behavior and 3) the biological properties of the brain are the result of genotype and developmental experiences.

Violence is heterogeneous. Physical violence can be impulsive, reactive or defensive; or it can be predatory, remorseless aggression. Violent behaviors can be related to intoxication from alcohol or psychosis or other neuropsychiatric conditions (e.g., dementia, traumatic head injury). Violent acts may be the result of personal (Oklahoma City bombing) or a cultural (political terrorism) belief systems. Violence can be sexualized (rape) or directed at a specific victim (domestic violence) or at a specific group (e.g., African-Americans, homosexuals, Jews).

Aggression is not violence. An aggressive person may not be violent. Aggression is a behavior characterized by verbal or physical attack, yet it may be appropriate and self-protective or destructive and violent. The complex set of behaviors recognized as aggression has been studied in man and animals for many years. Thousands of studies have examined various aspects of the neurobiology of aggression -- and the summed result is a better understanding of, simply, the neurobiology of aggressive behaviors within specific contexts, (typically animal populations in experimental conditions). Unfortunately, these insights have resulted in few advances in clinical practice or public policy related to domestic or community violence. Why ? Because the complexity of violence means that there is a complexity of neurobiology. The neurobiology of aggression, studied in the lab, leads to little insight into the neurobiology of racism or misogyny -- or anti-Semitism. Ironically, many violent behaviors are the result of a defensive response to perceived aggression. The neurobiology of fear, therefore, holds as many important clues to prevention and treatment interventions related to violence as the neurobiology of aggression. The neurobiology of hate -- or ideology -- remain unstudied -yet as surely as there are neurobiological mediators of aggression, there are neurobiological mediators of ideology.

The human brain mediates all human behavior -- all aggression -- all violence -- all fear -- all ideology -- indeed, all human emotional, behavioral, cognitive and social functioning. This three pound mass of 100 billion neurons and 1000 billion glial cells is infinitely complex. Yet certain principles of brain organization and function can lead to insights regarding neurological factors involved in violence and aggression.

The brain has a hierarchical organization, from the lower, more simple areas to the more complex higher cortical areas. Simple, regulatory functions (e.g., regulation of respiration, heartrate, blood pressure, body temperature) are mediated by the 'lower' parts of the brain (brainstem and midbrain) and the most complex functions (e.g., language and abstract thinking) by cortical structures.

The brain's impulse-mediating capacity is related to the ratio between the excitatory activity of the lower, more-primitive portions of the brain and the modulating activity of higher, sub-cortical and cortical areas (Cortical Modulation Ratio). Any factors which increase the activity or reactivity of the brainstem (e.g., chronic traumatic stress, testosterone, dysregulated serotonin or norepinephrine systems) or decrease the moderating capacity of the limbic or cortical areas (e.g., neglect, EtOH) will increase an individual's aggressivity, impulsivity and capacity to display violence.

As the brain develops and the sub-cortical and cortical areas organize, they begin to modulate and 'control' the more primitive and 'reactive' lower portions of the brain. With a set of sufficient motor, sensory, emotional, cognitive and social experiences during infancy and childhood, the mature brain develops - in a use-dependent fashion -- a mature, humane capacity to tolerate frustration. A frustrated three year old will have a difficult time modulating the reactive, brainstem-mediated state of arousal -- he will scream, kick, bite, throw and hit. However, the older child when frustrated may feel like kicking, biting and spitting, but has the capacity to modulate those urges. Loss of cortical function through any variety of pathological process (e.g., stroke, dementia, head injury, alcohol intoxication) results in **regression' --** simply, a loss of cortical modulation of arousal, impulsivity, motor hyperactivity, and aggressivity -- all mediated by lower portions of the central nervous system (brainstem, midbrain). Deprivation of key developmental experiences (which leads to underdevelopment of cortical, sub-cortical and limbic areas) will necessarily result in persistence of primitive, immature behavioral reactivity. And, thereby, predispose to violent behavior.

The most dangerous children are created by a malignant combination of experiences. Developmental neglect and traumatic stress during childhood create violent, remorseless children. This is characterized by sensitized brainstem systems (e.g., serotonergic, noradrenergic and dopaminergic systems).

Dysregulated brainstem functions (e.g., anxiety, impulsivity, poor affect regulation, motor hyperactivity) are then poorly modulated by poorly organized limbic and cortical neurophysiology and functions (e.g., empathy, problem solving skills) which are the result of chaotic, undersocialized development. This experience-based imbalance predisposes to a host of neuropsychiatric problems -- and, violent behavior.

As we search for solutions to the plagues of violence in our society, it will be imperative that we avoid the False God of Simple Solutions. The neurobiology of complex, heterogeneous behaviors is complex and heterogeneous. In the end, paying attention to the neurobiological impact of developmental experiences -- traumatic or nurturing -- will yield great insight for prevention and therapeutic interventions.

Comments or Problems

Thanks for visiting CIVITAS ChildTrauma Programs. We hope to hear from you again soon.

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Helping Families Support Healthy Brain Development

It is now clear that what a child experiences in the first few years of life largely determines how his brain will develop and how he will interact with the world throughout his life. Parents play the most important role in providing the nurturing and stimulation that children require, but they need information and support to develop good parenting skills. In the past, extended family members were often close by, offering advice and acting as role models for inexperienced parents. Young families today often live far away from grandparents and other family and rely more on community resources for information and support in parenting. There is much that communities can do to help families promote their children's healthy brain development.

Educate parents about the importance of early experiences for their children's development. Often parents don't know about the many little things they can do to foster their child's healthy cognitive and emotional development, like talking to the child beginning in infancy, reading to him from a very early age, and helping him play simple games. Parents, especially new or young parents, may also need help learning to recognize their child's cues that he is hungry for stimulation or has had enough.

.... *While good early experiences help the brain*

In some cases, written materials or a few sessions of parenting education classes may be all that a parent needs to learn how to provide his or her child with appropriate stimulation. However, parenting styles and beliefs that have evolved over generations, like rarely talking to babies, can be difficult for parents to change. Many parents benefit from community-based programs in which a parent group leader or a home visitor acts as a role model and friend, supporting parents in their relationship with their children. Programs that work with parents over several years can be very successful in helping them become effective "first teachers" of their children. (11)

Prevent abuse and neglect. Children who are abused or severely neglected are at extremely high risk of developing emotional, behavioral, social, and intellectual disabilities. By the time a child is identified as having been neglected or abused, these problems have already begun to develop. Greater attention must be given to preventing maltreatment before it starts. High-quality home visiting programs which start working with families as soon as the child is born have proven to be effective in preventing abuse and neglect. (12) The key to these programs' success is that they help parents manage the

Provide accessible, quality mental health services for parents. Research has shown that parents suffering from untreated depression often fail to respond sensitively to their children's cries and bids for attention, and that they are unlikely to provide the child with the kind of cognitive stimulation that promotes healthy brain development. (13) Other mental illnesses like schizophrenia can also dramatically affect a parent's ability to interact appropriately with his or her child. Proper mental health treatment for these parents can make a real difference in their ability to raise a competent, happy child.

Ensure adequate nutrition prenatally and in the first years after birth. Numerous studies have shown the devastating effects on intelligence and brain development of a lack of basic nutrients at the prenatal stage and in infancy and early childhood. Programs such as the Special Supplemental Program for Women, Infants, and Children (WIC) can be

experiences help the brain to develop well, poor early experiences can literally cause a genetically normal child to become mentally retarded or a temperamentally easy-going child to develop serious emotional difficulties.

they help parents manage the stresses of raising children before unhealthy patterns develop and things get out of control.

effective in ensuring that babies receive the kinds of foods they need to thrive. (14) Educational and outreach campaigns to alert women to the importance of nutrition in the first trimester of pregnancy would also be helpful in preventing problems that can arise in this critical period when brain cells begin to form.

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The Importance of Quality in Infant-Toddler Child Care

Increasing numbers of American infants and toddlers spend several hours each day in various child care arrangements because their parents work or attend school. It is critical that the care these children receive promotes their healthy growth and development. Too often, however, child care providers are poorly trained and do not provide children with appropriate stimulation. Research has shown that in the majority of infant care arrangements in the U.S., children are not talked to and played with enough, and they do not have the opportunity to form the kind of comfortable, secure relationships with a caregiver that will promote their healthy emotional development. (15)

Parents should be given information about how to choose quality care for their children. In addition, special attention must be given to the development and enforcement of child care licensing standards that promote high-quality care: adequate pre-service and in-service training for caregivers; low child-to-teacher ratios, and small group sizes. Finally, child care reimbursement rates for families moving from welfare to work must be high enough to fund well-trained teachers who can deliver developmentally appropriate care and education.

Conclusion

Like most children, Michael Stevens has a family that will provide the stimulation and nurturing that he needs to grow and develop to his potential. Unfortunately, rising rates of child abuse and neglect across the country and persistently high rates of school failure in some communities indicate that far too many children do not receive what they need during their first few years for healthy brain growth and development. Our increasingly technically and socially complex society cannot afford to continue to allow large numbers of children to miss out on the positive experiences they need in infancy and early childhood; the costs, in terms of lost intellectual potential and increased rates of emotional and behavioral problems, are too high. The new developments in brain research show us what children need; our challenge is to ensure that every child receives it.

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too little too late
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Brain research manifests importance of first years

By TIM SIMMONS and RUTH SHEEHAN , Staff Writers

An empty vessel to be filled. A lump of clay to be molded. This is how adults often regard a young child entering school.

But stunning discoveries about the human brain are shattering these assumptions.

Kindergarten is not the starting point of a child's brain development, scientists say. By kindergarten, the process is half over.

A child's potential is determined in the early years --from the first moments of life to countless hours spent in day care. These are the years when we create the promise of a child's future. This is when we set the mold.

The discoveries are so profound that many researchers say we will surely look back on the 1990s as the "Decade of the Brain."

Taking aim at the future: Claire Weintraub gazes curiously at a toy at the Frank Porter Graham Child Development Center in Chapel Hill. The center is a national leader in research in early childhood care.

STAFF PHOTO BY SCOTT SHARPE

In the past few years, for example, scientists have found that an adult's potential vocabulary is determined largely by the words filtered through the brain before age 3. The neurological foundations for math and logic are set before age 4. Emotional stability is greatly affected by how the brain develops in the first two years of life.

And the outcome is not predetermined, scientists say. How a child is nurtured plays a huge role in how the brain chooses to wire itself for life.

"There is no doubt that experience molds the young brain," says Dr. Harry Chugani, a pediatric neurologist at Children's Hospital of Michigan and a national leader in the field. "The early years determine how we turn out."

What matters most during this crucial period?Just about everything, it appears. For a young child's brain to thrive, the child needs to be loved, held, talked to, read to and allowed to explore. A child who lives in a world of daily stress and hostility will pay for it later. So will a toddler who is parked in front of a television for hours and hours every day.

Parents, of course, have the most to say about a child's experiences. But the flood of women entering the work force in the last 25 years --the biggest change in family life since the Industrial Revolution, some historians say -- has made day care an integral partner in the child-rearing process. Thousands of parents see their children for only a few hours a day during the workweek.

Day care is now the rule for most families, not the exception. In North Carolina, just over one-third of all children under 6 are cared for by a stay-at-home parent, according to the latest Census figures. That means the rest --more than 335,000 preschoolers --spend the majority of their waking hours outside their parents' reach.

Good start: Little Sterling Margrave gets some personal attention from Christy Farmer at the Frank Porter Graham Child Development Center in Chapel Hill, where he is in day care. How a child is nurtured plays a huge role in how the brain chooses to wire itself for life, scientists say.

STAFF PHOTO BY SCOTT SHARPE

Understandably, parents use safety as the most important yardstick of quality care. But early childhood experts have long argued that settling for safety ignores the more important issue of developing a child's potential. Today, neuroscience is providing striking confirmation.

Day care is more than a service that holds daily schedules intact. It is a place where children build their brains.

Invisible changes

Building pathways

From the moment a baby is born, each and every experience builds the neural connections that guide development. The young brain grows phenomenally in the first years of life, opening windows of opportunity for learning that occurs only once in a lifetime...

In many ways, the brain research of the past decade has raised two questions for every answer. As one mystery is solved, another unfolds. Meanwhile, our knowledge is growing by huge leaps.

Until the 1960s, most researchers thought of the brain as some sort of impenetrable box with its wiring largely determined at birth. Those interested in the inner workings of the soggy gray matter had only the lifeless brains of laboratory animals and human cadavers to provide clues.

But with the 1970s came scanning equipment, and soon after, improvements with each new generation of machines. By the 1980s, scanners were giving scientists a chance to see distinct areas of the brain in action. The result was an explosion in research and knowledge, culminating in the 1990s with one breakthrough announcement after another from the thousands of researchers now working in the field.

From only a handful of pathways at birth to trillions of connections by age 3, scientists now say, brain growth in the early years of life is unparalleled.

At no other stage does the brain master so many activities with such ease. At no other time does experience etch so deeply into our biological makeup.

Without a second thought, most parents simply enjoy the neurological miracle that produces vision, motor skills and a little nonstop chatterbox --all by the age of 5.

But equally profound changes take place within those five years that are practically invisible. They happen during what scientists call critical periods, or windows of opportunity.

It is during these periods that long, thin fibers grow inside the brain,

creating pathways that carry electrical impulses from cell to cell. The resulting network, which grows daily in the young brain, forms the neurological foundation upon which a child builds a lifetime of skills.

The connections needed for some skills form quickly. Vision, for example, develops in a matter of months. But it takes almost four years before the brain is done building the neurological foundations that allow a child to pick up a pin or to skip down the sidewalk.

Once the critical periods pass, however, they are gone forever. Improving a child's potential after these windows of opportunity close is far more difficult --and in some cases impossible.

The genetic blueprint that determines our potential comes with a major condition:To fully reach that potential, start early.

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Wired for learning

One of the few places in the nation where brain research and day care can be discussed comfortably in the same conversation is the Frank Porter Graham Child Development Center in Chapel Hill.

Founded 30 years ago and named in memory of the former University of North Carolina president and U.S. senator, it is among an elite group of research centers scattered across the United States. To those in the field, the center's work is well known on subjects as diverse as the spread of germs in day care and the long-term effects of quality care on a child's academic achievements.

Essential ingredient: Volunteer Ann Goode reads to her daughter Cara, right, and classmates at the Community School for People Under Six in Chapel Hill. If a young child's brain is to thrive, experts say, she needs to be loved, held, talked to, read to and allowed to explore.

STAFF PHOTO BY SCOTT SHARPE

Last year, the Frank Porter Graham center was given a role to play in helping set national policy when it was awarded a $14 million grant to coordinate research efforts throughout the country on early childhood care.

But all of that is lost on the roughly 65 children who attend the center's day-care program. To the toddlers in Harriet Reddick's class, research is the different noises one can make by banging a plastic shovel and then a plastic bucket against one of the playground toys.

Brooke, a little blond girl with all the curiosity you would expect in a child of 16 months, holds a green plastic bucket at arm's length. "Bu-bu-bu,"she repeats

'It's pretty outrageous what happens in those first years. They go from the blob stage to being this little, very interactive member of the family.'

Anne Goode

Chapel Hill, mother of Cara, 2 1/2

over and over.

"That's right, Brooke. It's a bucket,"Reddick replies

Brooke responds by shoving the bucket in front of anyone who will praise her for her discovery.

Although most of her communication is limited to two- and three-word phrases, Brooke is clearly about to cross the threshold of practical speech.

But this isn't something that has happened in the past few months. Her brain --like the brains of young children throughout the world --has been getting ready for this task since birth.

A child's brain, logically enough, has no idea at birth what language the child will be required to speak. So it comes equipped with the ability to learn any language, says April Benasich, director of infancy studies at Rutgers University.

At the same time the brain is forging thousands of new connections a day, it is also keying in on the repeated sounds of speech it hears, the tone of a person's voice and subtle verbal cues that go unnoticed by adults.

Happy to simply make noise at first, babies soon learn to specialize based on the sounds they have heard, according to research by scientists such as Patricia Kuhl at the University of Washington.

By the age of 1 year, a child is clearly developing a native tongue. She is learning to focus on the sounds of the language that surround her while ignoring sounds she is capable of producing but never hears. By age 5, the neurological connections needed to speak additional languages without an accent will be pruned away or put to other use.

Contrary to conventional wisdom, the young brain is more than capable of learning several different languages during this window of opportunity --with little effort or confusion.

"Neurologically speaking, there is nothing that prevents a child from learning two or three languages at the same time. The brain appears perfectly capable of that,"says Chugani, the neurologist at Children's Hospital of Michigan.

Scientists have long known that hearing disorders or chronic ear infections can impair a young child's speech or stunt his vocabulary. Now they are beginning to understand why.

If a child cannot properly hear and process sound during the critical period for speech, it is far more difficult for the brain to form the proper pathways and connections, Benasich explains.

[TOP]

Complex connections

At a little table near the back of their classroom at the Frank Porter Graham center, a small group of children gather around teacher Phyllis Royster.

While the 3-year-olds begin cutting pictures from magazines, other children gather around Laura Coble to play with blocks and toys. With a little prodding by Coble, the children soon are singing nursery rhymes and

counting games.

A neurological scan of these children would show sections of their brains literally glowing with electrical activity. This is the beginning of the period that defines a child's greatest learning potential --roughly from the ages of 2 to 10.

'The most important thing you can do is be proactive. Parents often know, they just don't know why.'

Dr. April Benasich

director of Infancy Studies at Rutgers University

Amazingly, what started in these children's brains as a few scattered connections and pathways has now developed into a tangle of interconnections of almost adult volume.

But compared with an adult, each child is putting far more effort into maintaining the connections he has generated.

At Children's Hospital in Michigan, Chugani is considered a pioneer in the use of a technique that allows researchers to watch the human brain in action.

The technique, known as Positron Emission Tomography or PET, scans for activity in a child's brain based on glucose consumption. The brightly colored pictures it produces make it possible to see what part of the brain is most actively engaged during given activities.

What the scans show in general is that the brain does not reach into one specific area to retrieve a single piece of information or a command. Instead, it relies on a complex network of connections that respond in concert to messages received by the brain.

This is what allows the children gathered around the table with Royster to cut out pictures, answer questions and giggle over something delightful all at the same time.

But the scans that Chugani works with show something else about the brains of children. The growth at this age is explosive, a fact that allows them to absorb and organize new information at a rate much faster than adults. Until the age of 10, children's brains show almost twice the activity of an adult brain.

Once considered static, the brain is revealing itself to be an amazingly adaptive organ. The trillions of connections that make up a child's brain are staggering for their complexity alone. But it is the speed with which these connections work simultaneously that makes the most powerful computers seem primitive in comparison.

Once a child reaches puberty, the brain activity that distinguishes the early years begins to ebb. By about age 16, the body's effort to maintain neurological connections hits a plateau, and it remains at that level throughout much of adult life.

The idea of critical periods for brain development was only a theory until a series of breakthrough experiments in the 1960s and early 1970s.

It was during that time that two researchers, David Hubel and Torsten Wiesel, performed experiments on how the brains of cats are wired for sight.

The research, for which Hubel and Wiesel won a Nobel Prize in 1981, showed that sewing one eye shut on an otherwise healthy newborn kitten prevented the cat from ever seeing when the eye was reopened. Even closing the eye for a few days caused permanent damage to the cat's sight.

'The brain knows what it wants, and if you give it a chance, it's

By denying stimuli to the kitten's eye during the brain's critical period for sight, the researchers prevented the formation of connections between the eye and the brain's visual cortex. Trying to develop the connections after the critical window passed proved fruitless.

going to make the most of the opportunities you present it.'

Dr. Larry Katz

Duke University neurobiologist

critical window passed proved fruitless.

"It forever changed the way we thought about brain development," says Carla Shatz, immediate past president of the Society for Neuroscience and a neurobiologist at the University of California at Berkeley.

[TOP]

Nature and nurture

The day-care program at Frank Porter Graham in Chapel Hill is almost utopian in its approach.

While most day-care centers in North Carolina struggle to meet minimum standards on tight budgets, the mission of the Graham center is to seek the best care possible for its children.

Teachers at the center earn between $24,000 and $37,000 a year, about two to three times the average for child-care providers in North Carolina. All have college degrees and most have a master's. The 12 infants who are enrolled at the center each year remain together until they leave at age 5.

In return for letting their children participate in the studies, parents receive model day care.

"This isn't what most parents are going to find when they start shopping for day care,"center director Debby Cryer says. "In fact, it's not the real world."

Indeed, on many days adults outnumber babies in the infant room as Cryer takes visitors from one crib to another.

The first rule in the infant room is obvious: No child who is awake goes unattended.

It's not that the teachers in the infant room don't like to hear children cry. As any young parent can confirm, no amount of attention can eliminate that.

Instead, the adults play with the children constantly because that is how children learn

"The brain is an association machine," says Dr. Larry Katz, a neurobiologist at Duke University who was a postdoctoral fellow with Wiesel in the 1980s.

"The brain constantly looks to link things together -- by sight, smell, sound and space.Then it calls on those associations to make sense of the world."

Although the brain connections formed before birth are critical, they

mostly allow for biological survival. Connections that are necessary to control breathing and heart rate, for example, have already been formed at birth.

But in the following months and years, nature and nurture tumble over one another until they become intertwined and inseparable.

Nature provides an organ that craves experience and association. Nurture guides the process, ultimately deciding which pathways in the brain will be used and which will be ignored.

All children learn. They can't help it. What they learn depends on what they are exposed to.

Timely lesson: Daniel Helfrich, 2, gets encouragement from his mother, Carol, during a Kindermusik class at the Raleigh Conservatory of Music. Researchers have found that the "window of opportunity" for learning musical skills opens early.

STAFF PHOTO BY SCOTT SHARPE

[TOP]

Emotional evolution

Even emotions appear to have a critical period of development, although the concept is still a murky one among researchers.

Feelings, personalities, emotions --in many respects the essence of what we are --have long been regarded as family traits passed fr .1 parent to child. A large body of work, for example, documents genetic li .s for emotional disorders.

But questions have lingered for decades about whether genetics alone dictates the emotions that define us. In some of the most famous social experiments of the 1950s, baby monkeys were separated from their mothers at birth and raised without parents. As they matured, they tended to respond to stress by hugging themselves while rocking back and forth. They also stared blankly for abnormally long periods.

Tragically, researchers see many of the same behaviors in children who were discovered in Romanian orphanages in the late 1980s. Now in elementary school, the children had been deprived of any nurturing for the first year of life or longer.

Those who have since been adopted seem to be adjusting to their new family settings, but they often have trouble developing socially. Psychologists report that some of the children react to stress by hugging and rocking themselves much as the monkeys did.

Others have a difficult time forming normal relationships with adults. Even though they are loved and well cared for, some will walk away with almost any stranger who is kind to them.

The idea that a critical window for emotional development contributes to these problems is bolstered by PETscans that show increased activity in the brain's frontal cortex between the ages of 6 months and 2 years, according to

Chugani. In older children and adults, that is the area of the brain that dominates emotions and complex thoughts.

But answers to how these circuits form --and why -- is still as mysterious to researchers as emotions themselves.

What isn't mysterious to Cryer, the director at the Frank Porter Graham day-care program, is what day-care operators should do with the findings.

Shortly after she took over as director last year, she stopped changing children's teachers at the end of the first year --a common practice in day care. Instead, she allowed the teachers to change rooms with their children as they grew older.

"Why rip them apart at the height of their social and emotional attachment?"Cryer says. "What are our priorities?"

At the end of a long morning, 5-month-old Nija coos in the arms of her teacher, Christy Farmer. At this time next year, the two of them will be working together in the toddler class. The emotional bond --as well as any underlying neurological connections --will remain intact.

[TOP]

A question of care

WhenChugani, the neurologist from Michigan, is invited to speak about brain development, he is sometimes joined by Craig Ramey. A psychologist at the University of Alabama, Ramey was a senior researcher at Frank Porter Graham for two decades.

Putting experts from early childhood and neuroscience at the same table is something that wouldn't have happened five years ago. Neither would have thought the other's field had much to offer.

But there is a growing awareness that something is seriously wrong with the way we raise our young children. Separately, neuroscientists and early childhood experts have reached the same conclusion:Ayoung mind denied opportunities is a young child denied potential.

Early childhood experts had suspected this for years, long before their own formal studies were completed.

Parents who rely on intuition sense it as soon as they are forced to search for quality care.

And neuroscientists --while reluctant to publicly pass judgment on day care -- tip their hand when it comes to making decisions about their own children.

Duke's Katz, for example, hired a nanny for his first child "because I can't really see anything good coming out a situation where one adult watches five children."

Chugani assumes that his young son will follow in his 12-year-old sister's footsteps and play several instruments, learn a foreign language or maybe do both. "Why shouldn't I expect it?"the father says.

Even politicians have pegged the issue as one they can't ignore. First lady Hillary Rodham Clinton will host a national conference on children and the family this spring. In North Carolina, Gov. Jim Hunt's early childhood

program, Smart Start, is built entirely upon the belief that people will respond to the needs of the state's youngest residents.

But it isn't likely that brain researchers will ever be able to tell parents what they really want to know:how to build the perfect brain. Many in the field are not even comfortable with the dawning recognition that they could dramatically change tomorrow's public policies or the way parents raise their children.

"Some of the assumptions people make about the human brain are logical, based on what we know so far, but we are not early childhood experts,"says Shatz, the past president of the Society for Neuroscience. "This is research."

Still, it is the type of research that drew about 75 of the nation's top educators and neuroscientists to a meeting in Colorado last summer to talk about common areas of interest and the possibility of joint projects.

Had the current discoveries of neuroscience preceded the day-care revolution by 10 years --instead of happening the other way around --Ramey, the Alabama psychologist, says he has no doubt that attitudes about day care would be different and that the public would demand a better system.

"But it's too late for that now," says Ramey, who has watched his own ideas about day care change between the births of his oldest child --who is now 30 --and his youngest, who is 4. "Our system of day care is bootstrapped upon the belief that day-care providers are baby sitters. First we will need to change that belief."

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April 3, 1998

The Honorable Con Bunde
Chairman, House Hess Committee
State Capitol, Room 104
Juneau, AK 99801-1182

Re: HB 369 and HB 375

Dear Representative Bunde,

I am writing in support of Governor Tony Knowles' Smart Start Initiative, and its pending legislation, House Bill 369 and companion measure Senate Bill 266 and House Bill 375 and its companion measure 272.

I feel that we, as Alaskan's can not afford to ignore the evidence of continued child abuse and neglect in our state. The Smart Start Initiative is based on the theory that early-childhood intervention programs result in a significant government savings.

Anything that you can do to further these important pieces of legislation would be greatly appreciated.

Sincerely,

Don Argetsinger
President

KLUKWAN, INC.
P.O. BOX 32077 • JUNEAU, ALASKA 99803-2077 • (907) 789-7361

April 3, 1998

The Honorable Tony Knowles
Governor
P.O. Box 11001
Juneau, AK 9981-0001

Re: HB 369 and HB 375
SB 266 and SB 272

Dear Governor Knowles,

I am writing in support of your Smart Start Initiative, and its pending legislation, House Bill 369 and companion measure Senate Bill 266 and House Bill 375 and its companion measure 272.

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Sincerely,

Don Argetsinger
President

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April 6, 1998

The Honorable Joe Green
House of Representatives
State Capitol, Room 118
Juneau, AK 99801-1182

Re: HB 369 and HB 375
SB 266 and SB 272

Dear Representative Green,

I am writing in support of your Smart Start Initiative, and its pending legislation, House Bill 369 and companion measure Senate Bill 266 and House Bill 375 and its companion measure 272.

I feel that we, as Alaskan's can not afford to ignore the evidence of continued child abuse and neglect in our state. The Smart Start Initiative is based on the theory that early-childhood intervention programs result in a significant government savings.

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STATE OF ALASKA

TONY KNOWLES, GOVERNOR

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OFFICE OF THE COMMISSIONER

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February 4, 1998

Honorable Con Bunde, Chairman
House Health, Education and
Social Services Committee
State Capitol Room 104
Juneau, AK 99801-1182

Dear Representative Bunde,

The Department of Health and Social Services respectfully requests a hearing in the House Health. Education and Social Services Committee on House Bill 375 "An Act relating to ch. .lren in need of aid matters.....; and providing for an effective date."

This bill was introduced by the Rules Committee at the request of the Governor. Fiscal notes were submitted at the time of introduction.

Attached is a two page summary of changes to the criminal and civil statutes included in the bill.

Based on previous conversations with yourself and Representative Joe Green, Chairman of the House Judiciary Committee, we understand there may be interest in receiving an overview of the legislation in the House Health, Education and Social Services Committee and House Judiciary Committee sitting in joint session. If a joint hearing is not desirable at this time, we request a hearing in the House Health, Education and Social Services Committee, the first committee of referral. Your favorable consideration of this request will be most appreciated.

Sincerely,

Elmer A. Lindstrom
Special Assistant to the Commissioner

Attachment
cc: Representative Joe Green, Chairman, House Judiciary Committee
Russ Webb, Deputy Commissioner
Pat Pourchot, Office of the Governor

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER

GOLDBELT PLACE
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(907) 465-2800
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January 26, 1998

The Honorable Con Bunde
Chairman of the House Health,
Education and Social Services Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Representative Bunde:

Today HB 351, the Governor's academic performance/accrediation/and foundation formula bill, was referred to your committee. I would like to request that you hold a hearing for that bill at your earliest convenience.

HB 351 includes a statewide comprehensive testing system, an expansion of report card requirements, a state accreditation system, and the proposal to hold schools accountable for student learning. It also includes our foundation formula rewrite. As we know that your committee will be holding hearings on the foundation formula this Tuesday, Thursday, and next Thursday, we hope that you will take action on this bill as soon as possible.

Last session your committee initiated and was successful passing the high school qualifying exam legislation. As the Department prepares to implement that law, we also look to you for support in establishing a statewide comprehensive testing system. It is our responsibility to make sure Alaskan students are well prepared for that qualifying exam when it is put in place.

Your support for K-12 education in Alaska is always appreciated. I look forward to testifying in your committee on behalf of this important piece of legislation.

Sincerely,

Shirley J. Holloway, Ph.D.
Commissioner

Cc: Pat Pourchot, Legislative Director
Office of the Governor