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Surgeon General's
Workshop on
Violence
and Public Health
Report

Leesburg, Virginia
October 27-29, 1985

Surgeon General's Workshop on Violence and Public Health Report

Sponsors

U.S. Department of Health and Human Services: the Alcohol, Drug Abuse, and Mental Health Administration, Centers for Disease Control, Health Resources and Services Administration, and National Institutes of Health of the U.S. Public Health Service and the Administration on Children, Youth, and Families and the Administration on Developmental Disabilities of the Office of Human Development Services

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Plenary Session I

Welcome and "Charge" to the Participants

Presented by C. Everett Koop, MD
 Surgeon General of the U.S. Public Health Service
 Sunday evening, October 27, 1985

Let me personally thank you all for accepting my invitation and coming to this workshop. Before we end our work on Tuesday, I hope I will have been able to thank each of you in person.

I will be here throughout the workshop, and I hope to visit each work group once to catch at least the sense of your deliberations.

I have also assigned each member of my "Ad Hoc Planning and Advisory Committee" to a specific work group. I have asked each one to be helpful to the chair when needed and in other ways carry my personal interest to — and from — those important work sessions.

I will also rely on them to help me frame my response to the recommendations that are to be presented in the fourth plenary session on Tuesday afternoon.

Because they've been so important to the planning of this workshop over the past 13 months — and because they continue to be important to the way we proceed — I'd like to take a moment to introduce them to you in

alphabetical order: Ann Burgess, Ted Cron, Margo Gordon, Dave Heppel, Tom Lalley, Bob McGovern, Nikki Millor, David Nee, Eli Newberger, Delores Parron, Mark Rosenberg, Saleem Shah, and Alan Wurtzel.

If you're still wondering by what magic your name came to my attention, please be assured that it wasn't through magic at all but rather through the diligence of this committee reaching out into the larger community. They spent almost five months searching out the best possible people to come together to share what they know and what they see as the things still to be done.

Let me hasten to add that many excellent people are not here and their absence may be noted. First, it is possible that we *did* invite them, but they either had to decline or, after accepting, found they could not make it after all. Others did not receive an invitation for the time-worn but unsatisfactory reason of space: We asked Xerox for just so many spaces . . . 150 of them . . . a number we felt was the maximum for a workshop in which we hope everyone will contribute.

But I would be very disappointed if this were both the first and the last workshop on this subject. I am hoping that our experience here will be repeated in the coming months in every region of our country and that, as a result, many of the people who are missing from this workshop will have a chance to contribute in the future through those follow-up events.

I understand that such may well be possible in the southwest, thanks to the people here from Texas. And later this week, my staff will be talking with some people from the midwest about a follow-up meeting there.

But the prize for immediate follow-up ought to go to the nurses who are here. A contingent of the "Leesburg Nurses" will form a panel and present the recommendations of this workshop on Friday evening, at the opening session of the "First National Nursing Conference on Violence Against Women," being held November 1 through 3 at the University of Massachusetts at Amherst.

Congratulations . . . good for you.

For most of you, I'm sure this will not be your only conference on violence this year. Some of you will have attended several before the year has ended.

But I hope the Leesburg Workshop will be different in one major respect: Our focus will be squarely on how the health professions might provide better care for victims of violence and also how they might contribute to the prevention of violence.

It is clear that the medicine, nursing, psychology, and social service professions have been slow in developing a response to violence that is

integral to their daily professional life. As a result, we are not sure if the estimated 4 million victims of violence this year will receive the very best care possible.

Nor can we be sure that enough will be done to prevent violence from claiming 4 million or more victims again *next* year.

I think we all share these nagging suspicions. Fortunately, we also seem to share the same notions about what can be done about them and how we can do it.

That is one of the interesting outcomes of the "Delphi" survey that so many of you took part in over the summer. According to the final report, we generally agree on many ideas that lead directly to action.

Multidisciplinary Approach

One such idea is that the best approach the health professions can make to interpersonal violence is a multidisciplinary approach.

We know we have not been as successful as we would like to be in the care and treatment of victims of violence because of the way our health professionals continue to indulge in compartmentalization . . . the vertical separation of one life-saving service or discipline from all others.

It's a frustrating habit we've developed, but one which we agree should be ended as soon as possible and as effectively as possible.

For just that reason, we have a range of disciplines, skills, and experience represented at this workshop. Through our own multidisciplinary deliberations, we might produce recommendations for the profession of medicine, for example, that not only reflect actual and potential medical practice, but also reflect the contributions of social services, nursing, and law enforcement, as appropriate.

Ideally, the multidisciplinary approach we're taking here in Leesburg ought to be replicated in every community in the Nation. I say "ought to," but I know it can't be accomplished in most of the country. Therefore, reality dictates that we produce here the kinds of recommendations that reflect the thinking of many disciplines, yet recommendations that can be — themselves — the stimuli of change and progress everywhere.

Here, again, through the "Delphi" technique, we seem to have reached general agreement on another idea, and that is the fact that we've had ample time to develop our theories and concepts. What we need now — and what the *country* needs now — is action.

Our recommendations, then, ought to be framed in such clear, direct language that our colleagues in medicine, nursing, psychology, and social

service anywhere in the country can absorb them, understand them, and put them into practice.

- We need to make such recommendations for all the health services . . . how they might be organized, how they should interact, how they ought to respond to the needs of victims of violence, and how they should contribute to the prevention of violence. To say we're in favor of a multidisciplinary approach is obviously not enough. We need to focus in on those current multidisciplinary programs that seem to work . . . to isolate and describe their elements . . . and then indicate how they can be replicated in any community or institution.
- We also need to be just as pragmatic in the area of education and information. How can we get certain life-protective messages across to young people? . . . to our elderly? . . . and to our colleagues in the health professions? And what role could our public schools, our professional schools, and our professional associations play in this educational effort? And what ought to be the role of the media . . . television, radio, newspapers, magazines?
- While we might feel we have learned enough from research and experience to move forward into action, there are still many areas — especially in the field of human behavior — where we could use more specific information based on good research and demonstrations. I hope these will be discussed here and later put forward among your recommendations, also.

From these two days of hard work should come a document that can be read in two ways. One way would be to read the recommendations, one by one, for the evaluation and treatment of victims and for the prevention of violence. These recommendations could apply to the various professions, to local and state governments, to voluntary organizations, and to academia according to a cross-grid of the different kinds of interpersonal violence: child abuse, spouse abuse, rape, and so on.

The second way to read the document would be not as specifics but as an overall strategic design.

One of the great deficits of our health delivery system generally has been its stubborn resistance to the development of any overall strategy of care. I will not concede that there's a good reason for this because there isn't.

But there is a bad reason. And that reason is our own unwillingness to

really try. We have become so used to a health system that grows and changes incrementally that we think that's the way things ought to be.

But that's not so.

And so I would hope that here at Leesburg we would not fall into the same particularistic trap that we bemoan as existing everywhere else.

Let's not do that. Let us instead arrive at a set of recommendations that make sense by themselves . . . but make even *more* sense when they are perceived together, sewn throughout a seamless fabric of lifesaving, dignity-preserving, quality health care.

I want that to happen here at Leesburg. I believe it's an assignment that is worthy of the knowledge, experience, and reputations assembled in this room.

And now a closing word.

It had been our intention to take the recommendations of the Leesburg Workshop back into Washington, D.C., and hold a press conference on Wednesday morning to make our findings public. However, I believe we've been given an opportunity to start the public education effort in a very important way.

Special Senate Hearing

I'm pleased to report to you that at 11:00 a.m. on Wednesday morning, we will be appearing before the Senate Subcommittee on Children, Families, Drugs, and Alcoholism to report on what will have transpired at this workshop. We are going at the invitation of the Chair of that Subcommittee, Senator Paula Hawkins of Florida, who has been a strong voice in the Congress on behalf of human life and family values.

I say "*we*" have been invited because Senator Hawkins has graciously asked six of our 11 work-group chairpersons to appear with me. They are Douglas Sargent, Anne Flitcraft, Lee Ann Hoff, John Waller, Jean Goodwin, and Jordan Kosberg. They will speak not for themselves, obviously, but on behalf of all of us. I deem it a great privilege to travel in such company. In fact, I'm delighted to go to Capitol Hill with any company at all. But especially with these six.

It's getting late and I know many of you are eager to exchange greetings with colleagues, visit the special presentations arranged in the meeting rooms as part of the "information exchange" this evening, and prepare for tomorrow's work.

So I will close with a little quotation from one of my favorite American writers, Henry David Thoreau. He seems appropriate for this setting.

In his marvelous book, *Walden*, Thoreau wrote, "It is characteristic of wisdom not to do desperate things."

So let us turn to our work with patience and wisdom, and not out of desperation. Instead, let us pledge that despair is over . . . for *all* our people.

And let's start here.

Thank you.

Plenary Session II

Interpersonal Violence and Public Health Care: New Directions, New Challenges

Presented by Marvin E. Wolfgang, PhD

Director, Sellin Center for Studies in Criminology and
Criminal Law, University of Pennsylvania*

Monday morning, October 28, 1985

The Founding Fathers of our nation had the wisdom and foresight to remind us in the Preamble of the Constitution of the great challenges and goals that lay ahead. Six national purposes, charges, and mandates for the future were boldly inscribed there as part of the national consciousness. As a nation we have sought in common cause to fulfill those purposes. To nurture and preserve that more perfect union after which our forebears sought, the nation has had to remain vigilant to protect its spirit and body from threats from both without and within. One of the most damaging and pernicious internal threats that has taken on major proportions over the course of our history is violence in its many forms and gravities.

Deep and longstanding concern about our nation's violent past and present produced the presidential appointment of the National Commission

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on the Causes and Prevention of Violence in 1968. For the first time at the national level this dark side of our heritage was illuminated systematically and in depth. The summary of the 13-volume report prepared by the Violence Commission chronicled with precision this enduring and pervasive national malady (U.S. Violence Commission 1969). Among the community of nations most similar to our own in culture and history, those modern, stable democratic states of Western Europe, our nation was planted at the summit in levels of lethal interpersonal criminal violence and collective civil violence. More recent documentation confirms these observations and suggests that America is also an international leader in nonlethal forms of assaultive conduct (Archer and Gartner 1984; Wolfgang and Weiner 1985). Indeed, as the Violence Commission established, the 1960s witnessed levels of violence which were substantially greater than those of preceding decades and ranked among the most violent in our history.

Since the 1969 report of the Violence Commission, levels of violence in our national community have increased dramatically, if we use official police records of criminal violence; or they have remained fairly stable since 1973 but at much higher levels than those documented by police sources, if we use reports of criminal victimizations (U.S. Department of Justice 1984; Weiner and Wolfgang 1985). Our nation not only suffers losses of stature and moral example because of its levels of violence, which exceed the proportions of kindred nation states, but also finds itself at its zenith in this ignobling respect.

Focus on "Tranquility"

The Violence Commission elected to carry out its charge by focusing on the means "to establish justice and to insure domestic tranquility," the first two national purposes penned in the Preamble to the Constitution. Tensions between justice and public tranquility and order were guiding concerns in the quest of the Violence Commission to understand and to prevent violence. In that analytical and philosophical context, violent disorder was dissected with the cutting instrument of criminal law and the system of criminal justice. Although various theories were used to reveal the causes of violence, the primary inquiry was from the viewpoint of violative and unlawful behavior.

The Founding Fathers seemed prescient in their deliberations and constitutional framing. They inscribed another viewpoint and objective into this nation's first legal document: namely, the promotion of the general welfare. Now this workshop on violence is fueled by that original national purpose. The disorders of violence are as much a challenge to the general

health and welfare of our nation as they are to its system of justice and law. Our objective at this assembly is to wed to the insights and advancements of law, order, and stability, those of public health and welfare.

Fused to "America the Beautiful" has been "America the Violent." Ours is a land in which people inflict morbidities and exact premature mortalities in enormous proportions and in many different ways. The nation has been, and continues to be, fearful of these assaults and related victimizations (Weiner and Wolfgang 1984).

The formal promotion of the public health initiative in response to violence is dated with the presentation of the U.S. Surgeon General's national health agenda, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services 1979), which identified 15 priority areas that, with properly targeted preventive interventions, would improve appreciably the health of the nation. This document was the wellspring from which soon flowed quantified and feasible policies to reduce violence and other threats to the national health and vitality (U.S. Department of Health and Human Services 1980). Our current workshop on violence, a direct outgrowth of these milestone precedents, can inaugurate a major and continuing enterprise by health care professionals to prevent and to heal the many wounds inflicted by violence on our nation's physical, emotional, and cultural corpus.

A Catastrophe and a Challenge

Many sources can be consulted to document the extent and character of these lethal and nonlethal interpersonal exchanges. Some of these sources are more reliable and nationally representative than others. However, one need not search much beyond the pages of the background papers prepared for this workshop to obtain a measured and riveting picture of the catastrophe and challenge which confronts the nation (U.S. Surgeon General 1985). Consider the most grave interpersonal exchanges. Homicide ranked as the 11th leading cause of death of Americans in 1980. Approximately 24,000 Americans died by the hand of another in that year, resulting in 690,000 potential years of life lost. These deadly assaults comprised one-seventh of all deaths by injury (Baker, O'Neill, and Karpf 1984). Most grimly, for a young black male aged 15 to 24, homicide is now *the* most likely cause of death. Indeed, over his lifetime, a black male is burdened by one chance in 21, compared to one chance in 131 for a white male, of dying in a lethal encounter (U.S. Department of Justice 1985). But the proportions of lethal exchanges are dwarfed by the numbers of morbid

nonlethal incidents. More than 1.5 million aggravated assaults of Americans age 12 or older were reported in 1980, representing a substantial number, indeed, of instances in which a deadly drama might have unfolded and been played out to a lethal conclusion.

These lethal and gravely assaultive episodes have their contexts of occurrence which shape the likelihood and character of the injurious interplay. It is fitting that the patterns in interpersonal violence which form the primary focus of this workshop are those imbedded in the family. The national tranquility is deeply afflicted by these disturbances in the domestic microcosm.

That intimate nuclear family unit which broke bread together at dusk and which huddled close to hearth and home forms a rich part of the national lore and folk imagery. But the American family has also had its darker side which has rarely turned public. As we are finding increasingly, the family united in common purpose and objective is frequently more a myth than a reality. Domestic life is often rent from within, making enemies of intimates. Domestic tranquility is, as we are becoming more aware, threatened profoundly by its internal dissensions, disruptions, and injurious and deadly conflicts.

Tallies vary, but convergent data point to between five and 20 percent of the adult population as being enmeshed in some form of spousal abuse, comprising approximately four million domestic partners. Nearly 50 percent of those husbands who batter their wives do so with brutal regularity, three or more times a year. Other data, from the National Crime Survey, indicate that nearly one-third of the nation's abused women are serially victimized. Spousal abuse may, in fact, be the foremost cause of injury to women.

Nor are the nation's children immune from assaults and batterings and sexual attacks by their parents and other guardians and caretakers. A recent national survey projected that nearly 1.5 million children and adolescents are subjected to abusive physical violence each year (Gelles and Cornell 1985).

Many abused children are sexually violated, forcefully or through the implicit threats of a parent or caretaker in a position of authority and power. Scant information exists but some figures are enlightening and alarming. In 1984, nearly 125,000 cases of sexually abused male and female children were reported to authorities. Prevalence figures for women who were sexually abused before age 16 run between 25 and 50 percent. Peak abuse ages for male and female children fall between 9 and 12. Between one-quarter and one-half of the abuse cases involve a family member or relative.

Little reliable information has been marshalled about the extent and outcomes of domestic violence suffered by the elderly. What few studies have been conducted are more exploratory than comprehensive. In view of the patterns and proportions of other forms of familial violence, it is unlikely that we will be heartened when these hidden figures are uncovered.

The domestic crucible is becoming increasingly recognized as having profound effects, both immediate and long-term, on its members who experience violence directly or indirectly. Physical pain and suffering and related physical morbidities are the more obvious distressing outcomes. Disturbances in emotional and social development and in important cognitive skills are, likewise, the insidious legacy of domestic violence. These consequences are now documented with greater regularity, as you are all aware.

Long-Lasting Effects

Of equal concern is the effect that domestic violence, particularly against our nation's children, can have on shaping similar behavioral forms beyond the domestic circle. Perhaps most disquieting, children who are battered, or who witness physical assaults among other family members, are more likely to carry the force of these episodes into their nonfamilial interactions in the form of a heightened chance of employing violence as a presumed legitimate interpersonal strategy. The legacy of the violent family is the enhanced risk of applying variations of this same violent behavior in contexts beyond the family setting.

The proportions and gravity of family violence and its facilitation of collateral forms of interpersonal violence argue persuasively for selecting the family as the locus of a primary initiative to apply health care approaches to the reduction and control of violence. The benefits and conquests of the medical and public health models are well known with respect to controlling and, in some cases, eradicating disease and the behavioral contributions to poor hygiene and health. Descriptive and analytical epidemiological research and practice have met great challenges of disease and injury on many fronts: in identifying high-risk populations, in tracing the mechanisms by which theoretical risk is turned into actual malady, and in applying the tripartite prevention strategy — primary, secondary, and tertiary interventions — based on epidemiological breakthroughs into preventive and control regimens. Agents, environments, and hosts have each been proper foci in meeting the challenge of disease control.

The instruments of the health care provider, the conceptual and meth-

odological perspectives employed in public health care, and the modalities of assistance and intervention that are practiced routinely in the health care setting have a legitimate and firm place as part of our national armament against interpersonal violence. Past medical and health care applications in this area, primarily in application to crime in general and to violent crime more specifically, have been restricted to a subordinate part of criminal justice and social problem perspectives. These applications formed what has been termed the "rehabilitative ideal" in criminology and criminal justice. Medical models of disease and pathology were transplanted from their indigenous public and private health settings and installed within the coercive regimes of our courts, prisons, and correctional facilities. The agents of crime and violence were the target of secondary prevention strategies. As substantial recent reviews of these efforts have shown, this restricted initial wedding of medical philosophies with criminal and penal philosophies has had impoverished results (Martin, Sechrest, and Redner 1981; Sechrest, White, and Brown 1979).

Discontent with the rehabilitative ideal has recently turned many of our colleagues to search for alternative ways to control serious behavioral outcomes such as lethal and nonlethal violence. Proposals of deterrence and incapacitation circulate widely and are undergoing continued close scrutiny. These strategies have unclear feasibilities and uncertain magnitudes of effect (Blumstein, Cohen, and Nagin 1978).

The time is propitious for public health perspectives to enter the arena of disciplinary and theoretical thought about the etiology of violent conduct. There are now no clear and strong positions about how to proceed in containing and, perhaps in some cases, eradicating interpersonal violence. The wisdom of many perspectives — particularly one such as your own which has won many battles against injurious hosts, agents, and environments — should contribute substantially to efforts to curb the advancement of interpersonal violence.

As central to the public health approach as its conceptual and methodological armaments is the position that health care is best learned, performed, and maintained when it is ingrained as part of individual and community hygiene, as part of daily routines and salient perceptions of what constitute good health practices. Preventive and control strategies which do not enlist the routine cooperation of those who are to benefit from these strategies can have some success but not as much as they might. Both the American public and those health care practitioners charged with securing the public safety and welfare must learn to consider violence prevention and control as part of their daily requirements and responsi-

bilities. The American people must feel free to appeal to family life centers, drop-in crisis centers, and in-home service programs, to name but a few of our emerging responses to violence, without fear of social stigma, reprobation, or sanction. Our nation must feel as comfortable controlling its violent behavioral urges and practices as it does in controlling bacterial, viral, and physical mechanisms of morbidity and death.

The responsibility to stand firm against interpersonal violence is not the exclusive preserve and discharge of our contemporary public caretakers and monitors — our law enforcers. Although criminal justice approaches may have their place and effectiveness as part of violence control strategies — such as the recent Minneapolis study of police response patterns to domestic violence suggests (Sherman and Berk 1984) — these strategies do not enlist the sensibilities and commitment of our communities. Public health care has been a leader in taking steps to form alliances and networks to make health concerns permanent public priorities and part of personal practices. Winning the public to the cause of treating violence as a health concern may well be, along with its research and methodological equipment, one of the major contributions of public health services.

Many participants here today, who represent diverse disciplines, travel in partnership to a common understanding of interpersonal violence and, by virtue of that understanding, seek to treat the causes and correlates of that violence. But there are barriers to reaching this common understanding, many of which have been articulated by the contributors to the workshop *Source Book*.

An Expanded Data Base

Epidemiological approaches to describing and analyzing violence require reliably gathered and valid information. Particularly important are longitudinal data that span the lifecourse of subjects and reflect the many settings, domestic and otherwise, which influence the origins and development of violent behavior. These data must include persons who are subjected to violent assaults and those who are responsible for assaults as well as the situations in which assaults occur. In the lexicon of health care, basic, extensive, and quality information is needed about hosts, agents, and environments. With these data, the progression and vicissitudes of violent careers, as we now refer to them in our criminological pursuits, can be examined effectively and precisely.

The collection and maximum utilization of primary data sources is, then, a priority which needs continued and substantial support. Because lifespan data often demand substantial time for collection and analysis, practitioners

who seek to use and apply the fruits of such research data must be patient while they are gathered and analyzed. Moreover, to realize our goal of diminishing the ravages of interpersonal violence, solid evaluation of programs which respond to these physical onslaughts must be initiated. All who are here should recognize this need. Greater efforts to conduct proper assessments of violence reduction and control modalities are integral to rational efforts to establish and perpetuate those modalities which, in a word, work.

Law and Liberty

Our analytical and social service initiatives must be joined to considerations of law and justice. Complex issues of personal and collective freedom and protection collide in the arena of violence legislation about dangerousness. Protective service action exemplifies this legal tension. What are the proper limits of intervention? At what point may health care practitioners legally and coercively enter domestic settings? When might such entry constitute an unlawful intrusion, a violation of freedom and liberty that may be more deleterious than those practices which the empowerment legislation was intended to curtail?

No less controversial and complex are legal issues about how to control responsibly the explosive armaments which take so many lives each year. We must acknowledge that firearms are used to kill people in the United States in frighteningly great numbers. Socio-cultural differences aside, the ready accessibility of firearms in the United States and their near inaccessibility in Japan probably play a major role in the 10,715 criminal homicides by firearms in the United States in 1980 in contrast to only 48 in Japan. Without this mechanism of death so generally and easily accessible, people would not kill, and people would not die, as frequently as they do.

The resolution of these and other legal questions is a pressing concern which many here in attendance have already begun to address. More attention to these issues will be required as public health care focuses on physical violence and dangerousness.

To meet the needs of data preparation and analysis, of program evaluation, and of framing informed and effective legislation, greater public health efforts to confront violence must be focused and collective.

Surgeon General Koop's challenge to cleanse and to treat the national wounds of our present violence — a challenge he has laid squarely before each of us — can be met only if there is a broad-based, comprehensive agenda and an alliance of participants. Initiatives must be clearly articulated, feasible, and nationally coordinated for the optimum benefit to ensue.

The Surgeon General's office has been and will continue to be a seat of leadership in that enterprise.

But violence cannot be countered by government alone. The strengths of community and common cause are also required to promote health and well-being in our land. An alliance between public and private sectors should promote progress toward reducing violence. Some major private sector initiatives, such as the Eisenhower Foundation, presently exist and provide comprehensive plans for future action (Curtis 1985).

In summary, our common challenge is one of forging a national agenda and alliance in response to interpersonal violence and, by so doing, to promote and safeguard the general welfare. At the vanguard of this enterprise is the authority and good offices of our entrusted advocate of the public health, the Surgeon General. Perhaps this workshop marks the commencement of a dialogue which will culminate in a message from our nation's chief public health officer about the clear and present danger posed to the American people by violent conduct.

Toward achieving, in concert, the goal of forcing a decrease in our nation's violence, we must act with vigor, imagination, and resolve.

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Violence and Public Health

Presented by William H. Foege, MD

Assistant Surgeon General, USPHS, and Special Assistant for
Policy Development, Centers for Disease Control
Monday morning, October 28, 1985

I can't pretend to tell you much about the problem of violence. You come already schooled in the subject, convinced of its importance, and concerned by its impact. I will instead make a few observations about how this compares with other public health problems and what we can learn from our public health experience regarding how to pursue the problem of violence.

An Historical Preview

Throughout history, the two leading causes of early or premature death have been infectious diseases and violence. Infectious disease control started 190 years ago with the work of Jenner, when he developed the first vaccine, smallpox vaccine. Infectious disease control continued along with many nonspecific social changes, such as better nutrition, better housing, and education. In the past 50 years, we have returned to some specific tools, including vaccines, antibiotics, and pesticides.

On the other hand, violence has defied the best minds in health, politics, religion, and law enforcement, and therefore has often appeared to be inevitable. This and other forms of fatalism must be actively opposed. That we live in a cause-and-effect world is as true with violence as with infectious diseases, an important observation for both public health people and educators.

Another important observation is that public health is in the business of continually redefining the unacceptable. This changes the social norm which in turn changes the problem. For example, 35 years ago, polio was the inevitable price of summer in this country. With the widespread use of polio vaccine 30 years ago, the social norm in this country quickly changed. However, for the hemisphere as a whole, the social norm has been polio control or relatively low levels of polio disease. On May 14 of this year, the Regional Director of the Pan American Health Organization announced that polio would be eliminated from this hemisphere by 1990.

With that one announcement, the social norm changed, and it instantly became unacceptable to have any cases of polio in this hemisphere.

This conference is an important step in redefining the unacceptable in interpersonal violence. It is a major step in enlisting the public health structure of this country in changing the social norm. It should be understood that many have seen violence as being unacceptable just as many saw polio as being unacceptable. But until recently, violence has not been regarded as a public health problem. Rather, it has been viewed as a law enforcement problem, or as a transportation problem, or a welfare problem. Dr. Koop is largely responsible for putting this on the public health agenda.

Recent Developments

In 1977, a group began looking at morbidity and mortality in this country to advise on the 12 most important things that could be done in prevention. They made popular the notion of not only looking at the leading causes of death but also looking at the leading causes of years lost before age 65. While heart disease, cancer, and stroke lead the list of causes of death, the leading causes of years lost prematurely are accidents, cancer, heart disease, homicide, and suicide. Therefore, three of the five leading causes of premature death are related to violence. It was because of this finding that we started a program of violence epidemiology at CDC and hired Dr. Mark Rosenberg who has training in both psychiatry and epidemiology to head that program.

In 1979, the Surgeon General published his book *Healthy People*, outlining the 15 priority areas requiring national attention in prevention. Also in 1979, the first meetings of health people from around the country were held to develop the 1990 objectives, a set of over 220 specific objectives of where the United States should be in health by 1990. These include specific objectives on homicide rates, child abuse rates, and suicide, as well as on specific risk factors. This national prevention strategy is a landmark in public health, and it is important that violence is a part of the strategy.

In 1985, the National Academy of Sciences and the Institute of Medicine published *Injury in America — A Continuing Public Health Problem*. It pointed out that injury, both intentional and unintentional, remains the major unaddressed public health problem of our day. While injury accounts for 4.1 million years of life lost before age 65 each year, heart disease and cancer combined account for only 3.8 million years lost before age 65. Yet, we spend \$1.622 billion per year on research for the latter and only seven percent of that amount on injury research.

Basic to every successful public health effort has been the development of an appropriate surveillance system. This was true of the public health pioneers, such as Jenner, Snow, and Semmelweis, who did limited but rigorous surveillance of a microcosm; but it is also true of the institutional pioneers who have developed surveillance of cities, provinces, and then entire countries.

The first nationwide surveillance system for any disease in this country was not instituted until 1950. That system was developed for malaria and made the startling discovery that indigenous malaria had quietly disappeared from this country some time in the 1940s without being noticed. We did not organize another nationwide surveillance program for five more years. In 1955, because of a problem with polio vaccine which still contained virulent virus, a nationwide poliomyelitis surveillance program was launched, literally overnight.

Global surveillance for a disease was not developed until the late 1960s as part of the smallpox eradication program. While it may appear late to develop violence surveillance programs, in fact, surveillance in general is in its infancy.

Surveillance is essential if there is to be a concerted effort in violence control. We must define all aspects of the problem, collect relevant and correct data, analyze that data in order to define interventions, and measure the impact of those interventions. There are no short cuts. While we are beginning to get better mortality data by age, sex, time, and geography for homicide, we are only beginning to understand the dimensions of nonfatal outcomes. As Mark Rosenberg has pointed out, that may represent an even larger social problem than mortality. And we are a long way from knowing how best to use that information to suggest the generic changes most likely to have a favorable impact.

The Context of Violence

While good national surveillance is one key lesson, another is the need to understand violence in its broad context. Most certainly, we should view intentional and unintentional violence together. The surveillance network needs are similar; the risk groups overlap; the risk factors, such as alcohol and depression, overlap; and the instruments, such as cars and guns, overlap. But in addition, violence is not limited to physical injury. Deprivations of many kinds are forms of violence. Discrimination is a form of social violence, as is poverty. Indeed, Gandhi once said that poverty is the worst form of violence. And the threat of nuclear war constitutes a violent cloud over all of us.

While study requires us to narrow the focus, just as we do when studying the nervous system or the gastrointestinal system, this study must be done within a conceptual framework that understands the broad scope of violence. It is important to capture the momentum of nonviolent movements and prevent fragmentation of our efforts. The recognition of the International Physicians for the Prevention of Nuclear War for this year's Nobel Peace Prize is a significant indication of anti-violence movements which should be incorporated in the total effort.

Role of Health Departments

Health departments should be seen as crucial and essential but not sufficient. This is a lesson learned in many areas, even in what is regarded as standard public health. Health departments are simply not strong enough, sufficiently influential, nor rich enough to carry out programs by themselves. Around the world, we see this with immunization programs which become possible only when political leaders and others provide their support. In the United States, polio immunization rates were as low as 65 percent in 1977. It was not until the executive and legislative branches of government became involved with the states and counties, as well as education departments, PTAs, volunteer groups, etc., that immunization rates in this country went to 80 percent, 90 percent, and finally to 97 percent. This comes close to a program of perfection, but it could not have been done by health departments alone.

With violence, it is even more important to have the largest diversity of professional and volunteer groups possible if a significant impact is to be realized.

What then should be the role of health departments? *First*, health departments could assist to get violence into the mainstream of public health. Public health could provide the constituency that anti-violence now lacks. *Second*, health departments could be involved in problem definition, an area of considerable experience and expertise. *Third*, health departments could be involved in the education of politicians and those who could change what is now done, education of children through the development of appropriate curricula, and education of the public by providing information to the media. *Fourth*, health departments should develop intervention strategies and evaluate their impact. *Fifth*, health departments must work to keep this interest from being a fad. They must develop the stabilizing interest to sustain a search for answers into the future. This is particularly true if early intervention efforts turn out to be misplaced.

It is important for the Federal Government to provide leadership, as is being done with this conference. But it is essential that you not wait for the Federal Government to develop a program. Most health programs at the federal level have evolved because of convincing demonstrations at local levels. This was true for the immunization program which was built on many private, local, and state demonstrations. One of the telling examples is the use of child restraints in this country. The Federal Government for a variety of reasons could not or did not provide leadership. A pediatrician and local health officer in Tennessee worked at county and then the state level to get the first child restraint law passed in Tennessee. In only a few years, all states had followed the example.

It is important to promote a groundswell of trials, demonstrations, and suggestions from private sources as well as local and state health departments. Many pilot projects of varied types increase the chance of funding some interventions that are worth replicating. You force the federal establishment best by demonstrating something so compelling that it has to be replicated (as with child restraints).

International Implications

Finally, remember the international aspects of violence. We saw the disparity in homicide rates by country and the exceptionally high burden of violence endured by many. Although the developing world is quite correctly concerned with reducing its infectious disease rate, some Third World countries are already losing more premature years to violence than to infectious diseases. A broad perspective in studying violence and developing intervention strategies will serve the world most completely.

Smallpox is the only disease to have been eliminated from the world. As a person interested in that program, as well as international health generally, I can assure you that you are on the ground floor of something more fundamental and ultimately more important than smallpox eradication. The single most important lesson of smallpox eradication was the demonstration that it is possible to plan a rational health future. What you are now doing is a step — a vital step — in planning a rational future for combatting violence.

Plenary Session III

Interpersonal Violence: A Comprehensive Model in a Hospital Setting — From Policy to Program

Presented by Karil S. Klingbeil, MSW, ACSW

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Monday morning, October 28, 1985

Over the past several years, there has been an increasing focus on family violence: the issues, the characteristics, the components, the etiology, and intervention/prevention strategies. This focus on violence comes at a time when we have evidenced dramatic changes in the health of our citizenry. Many successful advances in treating illness and communicable disease are well known. The attention to traumatic injuries, then, and the development of major emergency facilities and trauma centers across the nation have literally forced health care providers to deal with all types of catastrophic injuries. Included are trauma injuries from interpersonal violence, both intra-family violence and extra-family violence. Gunshot wounds, knifings, physical beatings from other "lethal" weapons, sexual assaults, elder abuse, and the psychological aftermath plague the provider. The picture that has

emerged is a frightening one. Clearly, family violence is a major public health concern and requires a community response.

As with most health care issues, clinical demands and frustrations precede the scientific explorations, and family violence has followed this pattern. Particularly evident over the years has been the frustration of emergency room personnel as physical injuries from family violence have dramatically escalated, and police, medics, and others have brought victims by the thousands for emergency care. Many have literally been saved from "death's door," while others have not been so lucky. Even those "saved" often return to the precarious environment from whence they came, only to repeat their journeys to the emergency facilities, much to the disgust and ongoing frustration of the health care, criminal justice, and social service systems. Further, while emergency medicine has become a certified medical specialty, emergency room personnel are still ill-prepared to deal with the emotional and psychological impact of family violence. Emergency rooms also function as social service agencies after 5:00 pm and on weekends, when most agencies are closed and victims of violence gravitate to emergency rooms for psychological as well as physical attention. Whether emergency room staff are prepared or not, they must deal on a round-the-clock basis with all aspects of interpersonal violence.

Priority Populations

Harborview Medical Center, founded in 1877, is a 340-bed tertiary care teaching hospital affiliated with the University of Washington in Seattle. From its inception, Harborview has served the indigent medically ill of King County. Its priority populations, announced by the Board of Trustees in 1984, are persons in the King County jail; mentally ill patients, particularly those treated involuntarily; persons with sexually transmitted diseases; substance abusers; indigent patients without third-party coverage; non-English-speaking poor; trauma patients; burn patients; and those requiring specialized emergency care (victims/perpetrators of violence).

Harborview Medical Center is also the major emergency facility in Seattle, King County, and the Pacific Northwest. Most medical, psychiatric, and psychosocial emergencies are brought to Harborview's Emergency Trauma Center (ETC). Specific county commitments with the Division of Human Services, including the Involuntary Treatment System (ITS) and the Division of Alcohol Services (DAS), bring the acutely disturbed psychiatric patient and the excessively intoxicated patient for care. In addition, because Harborview is a designated regional trauma center for the Pacific Northwest,

it provides care to the majority of multiply injured patients in Seattle and surrounding environs, including the states of Washington, Alaska, Montana, and Idaho (referred to as the WAMI region). Annual traffic through the ETC averages 40,000 visits in a city and county with a combined population of 1.3 million.

It was from this clinical experience, coupled with an interest and commitment to help as well as to prevent, that the Harborview Medical Center project on interpersonal violence developed. The results of violence are most frequently treated in hospital emergency rooms. Thus, the emergency room has a unique opportunity to identify, intervene, assess, and treat interpersonal violence. The emergency room provides access to a population that often is too frightened or ashamed to seek assistance from traditional social work agencies; these patients seek the anonymity of a large, busy, often impersonal health facility (Clement, J., unpublished paper, 1985).

The Social Work program in the emergency room began in 1971. One of the goals was to evaluate needs of the emergency room population and to develop programs sensitive and responsive to those needs. In the next decade a series of problem areas were identified and clinical protocols for intervention initiated. The Social Work Director and the Medical Director of the emergency room wanted very much to provide services to victims of violence and provide leadership in the area of interpersonal violence throughout the city, county, and state. The goal was to define the health problems of a patient not just by the presenting symptom but by the primary diagnosis. This meant that a woman's broken arm may need to be explored as a case of domestic assault, that a seizure or pancreatitis may indicate a need to explore the patient's alcohol use, or that a straight wrist laceration might require exploration as a suicide attempt.

Six Different Protocols

The clinical protocols established a standardized model of detection, assessment, and intervention specifically for victims of interpersonal violence. They now include the Child Abuse Protocol, the Adult Abuse Protocol (wife battering, spouse battering, partner battering), the Sexual Assault Protocols (including incest victims, male and female), and the Elder Abuse Protocol. The Grief Reaction Protocol addresses services to family members of suicide and homicide victims. The Psychiatric Evaluation Protocol provides services to patients with a psychiatric illness or alcoholism who have been violent or who have the potential for violence and are "at risk." The beginning of the intervention process is dictated by "criteria for involve-

ment" by the social worker. It remains imperative that the criteria be as broad as possible, rather than include only those persons who are clearly identified as victims (Clement, J., unpublished paper, 1985). This initial approach is the key to detection of all problems of family violence and sets the scene for early intervention and prevention.

(For additional information on the Social Work program in the emergency room, the reader is referred to "Social Work in the Emergency Room," Clement, J. and Klingbeil, K. in *Health and Social Work*, November, 1981 and "Emergency Room Intervention: Detection, Assessment, and Treatment" by Klingbeil, K. and Boyd, V. in *Battered Women and Their Families*, Springer Publications, 1984.)

This paper presents a comprehensive model for handling interpersonal violence in a hospital emergency room. The goal is to recognize, detect, assess, and treat all forms of violence against persons. This model, while initially established in a hospital-based emergency room, is applicable and replicable in other settings as well. Special focus is on tertiary and secondary prevention; however, the model does address primary prevention of interpersonal violence as an overall but often elusive goal. Complementary to the model is the necessity to consider allocations of personnel, including support staff, other budgetary considerations, and space allocation.

These are the steps for development of the comprehensive model.

1. Policy Statement

The first step is the clear articulation of a policy statement sanctioned by the governing board or executive body of the institution. This is critical for any program in interpersonal and family violence. Myths and personal judgments continue to cloud the detection of violence between relatives, friends, acquaintances, or strangers. A policy statement demonstrates commitment, sets priorities of staff time and resources, and requires the administration, through the budgetary process, to allocate monies to an interpersonal violence program.

Institutional commitment to a policy of non-violence is a major step toward primary prevention and is as important to staff as to clientele.

This is an example of a policy statement:

"Harborview Medical Center (Faculty, Staff, Departments) acknowledges a responsibility in the tertiary, secondary, and primary prevention of violence. This includes the detection, assessment, and diagnosis of all aspects of interpersonal violence, the identification of high risk individuals and

groups, and the development of resource networks and/or primary preventive efforts as resources permit.

"The policy addresses two major areas:

A. Intra-Family Violence

1. Spouse battering
2. Wife battering
3. Marital rape
4. Child abuse
5. Incest (child sexual abuse)
6. Sibling abuse
7. Elder abuse
8. Abuse of parents by children

B. Extra-Family Violence

All forms of violent acts against another person not related in an intimate situation.

"Suicide attempts (and homicides) are frequently present in the above categories and require the use of the Psychiatric Protocol for assessment purposes. The interventions may differ, but sensitive and nonjudgmental assessment and diagnosis is imperative. It is important to note that the major difference between A. (Intra-Family) and B. (Extra-Family) is in the definition of the relationship: i.e., violence occurring in the context or absence of intimacy."

The appointment of a hospital-wide committee on interpersonal violence is detailed in Step 3 (see below), but could be included as part of a policy statement.

2. Background/Justification Data

After the policy statement comes the justification of the program, with appropriate background and substantiating information. This includes information on specific problems, such as child abuse, wife battering, suicide attempts, etc. This second step also requires a definition of terminology, including the kinds of abuse and the distinction between abuse and battering. Abuse occurs in the physical, psychological, sexual, and environmental contexts. Additionally, there should be a statement of philosophy, principles, and the identification of high risk individuals or groups by critical identifiers for diagnostic purposes.

Thus, step two addresses the following key areas:

- A. problem statement
- B. definition of terms
- C. philosophy
- D. principles: standards of practice

- E. magnitude of the problems — statistics
- F. demographics, if applicable
- G. behavioral characteristics or descriptions
- H. identification of high risk individuals/groups
- I. bibliography and references

This second step clearly articulates the justification and philosophy for a violence program in the emergency room. In other words, anyone reading Step 2 would understand the extent of the problem, the need for intervention, methods of intervention, etc.

Philosophy is important to any program, particularly one where there are varying opinions and myths that prohibit appropriate diagnosis and intervention. A comprehensive philosophy should include a statement on non-violence as a way of life — that violence is not justified in any relationship except in self-defense. Additionally, it should address the continuum of violence, from child abuse to elder abuse. It should clearly address prevention and lay the groundwork for education of client and professional.

Definitions can be relatively simple: for example, "... family violence is defined as behavior toward a family member that would evoke legal action if directed toward a stranger." ("Family Violence Principles of Intervention and Prevention," Jean Goodwin, M.D., *Hospital and Community Psychiatry*, Oct. 1985). Or family violence includes any act of force or coercion against another person without his or her permission.

Additional philosophical statements can deal with treatment strategies, advocacy, community resource building, and networking.

3. Procedures

The third step in this model is the development of specific, recommended approaches to various problem areas in interpersonal violence. Obviously the emergency room would have quite specific and detailed protocols pertaining to interpersonal violence, while other departments in the hospital might not. All departments, however, should have written procedures in concert with the overall hospital policy. As an example, a nursing department policy/procedural statement might address staff development and inservice training in support of the overall hospital violence policy.

The third step would include protocols, if the department is involved in "hands on" tertiary care. Otherwise, a statement of how department policies mesh with hospital policy will suffice.

A sub-step is the development of literature, including brochures and pamphlets on community resources as handouts to patients and their fam-

ilies. Copies of regulations and/or the law should also be available, either attached to a specific protocol or referred to in a department procedure. Both brochures and copies of appropriate laws might be included in the patient's admission packet, but would in any case be available in the emergency room as handouts.

An overall multidisciplinary hospital committee on interpersonal violence should be established. This committee could assure continued attention to protocols, referrals, resources, and resource allocation (including staff time, and budget). The committee should review hospital policy and update it as needed. Additionally, the committee could focus on political issues in the community, including public policy issues, statewide as well as local funding issues, and environmental trends. Secondary and primary prevention involve activities well beyond direct service, such as advocacy and testimony regarding proposed legislation. A hospital committee can provide leadership through legislative action. An interdisciplinary or multidisciplinary hospital committee can advance staff training on various levels, such as employee orientations to "Violence Rounds," a major educational pathway.

4. Protocols

The fourth step includes the development of specific clinical protocols for use in the emergency room. The clinical protocols include:

- | | |
|----------------------------|------------------------------------|
| A) Adult Abuse Protocol | E) Elder Abuse Protocol |
| B) Child Abuse Protocol | F) Psychiatric Evaluation Protocol |
| C) Sexual Assault Protocol | G) Alcohol Protocol |
| D) Incest Protocol | H) Grief Reaction Protocol |

Protocols should convey a clear commitment to exemplary, non-judgmental patient care. (See Klingbeil, K. and Boyd, V., *Battered Women and Their Families*, Springer Publishers, 1984). This is especially important for standardizing a level of care regardless of previous staff training.

The protocols should include all laws that apply to crimes of violence, reporting requirements, and victim compensation, if applicable.

5. Resource Management

Step 5 calls for the establishment of a resource "bank" or network of community agencies to which victims, families, and perpetrators may be referred. This can involve the development of new programs within the hospital and/or community as needs arise and are identified. This important

step extends the boundaries of the hospital into the community and develops an effective "safety net" for patient care. Conversely, the community comes into the hospital.

Resources can be identified in a number of ways but should include the following:

- Criminal justice system for reporting and investigative purposes, as well as treatment planning.
- Social service system for victims, perpetrators, and children; includes mental health, alcohol, resources, and self-help. Crisis to long-term care facilities should be identified.
- Advocacy and legislative groups, including national professional organizations, such as AMA, APA, APsA, NASW, ANA, and state-wide organizations.
- Religious community
- Welfare agencies
- Health care system
- Educational community

6. Organizational Component

The sixth step concerns the organization of an interpersonal violence program. Specific areas are as follows:

- A. Population served
- B. Practice and Standards by Discipline
- C. Supervision — Peer Review Leadership
- D. Knowledge and Skills
- E. Protocols — Clinical Aspects
- F. Program Development
- G. Administrative Structure and Staffing
- H. Demographics and Community Trends for the Future
- I. Budget

Extra-Family Violence

So far the focus has been on intra-family violence issues. Now let's turn to extra-family violence. To the six steps delineated above we would add the identification of high risk populations in regard to extra-family violence.

The identification of high risk individuals or groups seen in the emergency room is important in secondary prevention. Clinical impressions tell us that many individuals, particularly those involved in extra-family vio-

lence episodes, have previously been seen at hospital and health care settings. To identify these individuals and to intervene prior to a violent act is the purpose of secondary prevention.

These are some of the high risk categories:

1. Psychiatric diagnosis such as depression
2. Alcohol diagnosis (including DWI) and substance abuse
3. Behaviors associated with loss, grief, death
4. Isolation
5. Lack of support system
6. Homelessness
7. Previous history of assault/suicidal behavior
8. Chronic unemployment
9. Presence or use of weapons, previous arrest for crime, etc.
10. Runaway
11. Single auto accidents
12. Psychosomatic complaints

This is a list of "red-flag" antisocial and delinquent behaviors. These categories are important to early case finding and early intervention, since these patients most frequently show up in the emergency room. Their identification would be followed by the use of screening devices, such as violence scales and/or inventories which are particularly useful to an emergency room staff. Many scales and inventories in the trauma literature can be adapted for interpersonal violence behaviors. Emergency room staff could apply such scales to individual patients and hopefully begin to predict the level of lethality in future violent episodes.

Summary

This paper illustrates the steps in a comprehensive model for the identification, assessment, and treatment of victims of violence in a hospital setting. A crucial step is the use of clinical protocols which specifically detail the detection, assessment, intervention, and referral procedures.

Various hospitals in the country have moved ahead to develop family violence programs in their emergency rooms and outpatient clinics. Few programs in hospitals have also included extra-family violence.

Once the extra-family violence groups can be identified through protocols such as the psychiatric assessment or alcohol protocol, both assessment and early intervention techniques can be addressed. Assessment and primary diagnosis are imperative to early intervention. Strategies must be developed to identify patients-at-risk and to promote listening, caring, and helping

for this highly vulnerable population. Education of staff is essential. Programs need to be developed that reach out to these people, who frequently do not seek help in the early stages of trouble. Networking with social agencies must be accomplished. Attention should be given to tracking systems, since this population frequently "shops" for care (but confidentiality issues must also be addressed).

It is clear, however, that much can be done to reduce violence in our society without massive new resources. We must begin with the idea that an approach found successful in intra-family violence can be adapted for extra-family violence, too. Protocols can be developed, modified, and expanded. Protocols also lend themselves to audit and quality assurance accountability.

Every hospital in this country should have a policy and procedural manual on interpersonal violence. Lack of attention to this critical area can mean more health care dollars poorly spent and many lives needlessly lost.

Interdisciplinary Interventions Applicable to Prevention of Interpersonal Violence and Homicide in Black Youth

Presented by Deborah Prothrow-Stith, MD

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Monday morning, October 28, 1985

Interpersonal violence and its most devastating outcome, homicide, are endemic in urban black areas with low socio-economic indicators. Those who are most affected are young and male. Homicide is the leading cause of death for black men ages 15-24 years at a rate of 72.5 for every 100,000¹ and for black men ages 25-44 years at a rate of 125 for every 100,000.² These rates are 7-12 times higher than homicide rates for the general population.³

Non-fatal interpersonal violence occurs at rates that are at least a magnitude higher than homicide and likely represents an even greater overall cost to society. There is less adequate data on non-fatal interpersonal violence. Emergency room and school data are the best sources of rates for non-fatal interpersonal violence. However, these rates are underestimations because, as we know, many episodes of interpersonal violence are neither treated in emergency rooms nor do they occur in schools.

The Northeastern Ohio Trauma Study measured the incidence of cause-specific trauma by collecting emergency room data for the year 1977. The study reported an assault rate of 862 per 100,000 population. The overrepresentation of urban blacks of lower socio-economic status was demonstrated in this study as well. The incidence rate for assault in the urban black neighborhood was over twice the total incidence rate and up to six times the lowest neighborhood rate.⁴

School-based data are equally compelling. During the 1969-70 school year, Seattle Public Schools had four assaultive injuries per 1,000 students.⁵ In the U.S. generally there are approximately 75,000 assaultive injuries to teachers a year at a rate of 35 per 1,000.⁶ A November 1983 publication from the Boston Commission for Safe Schools⁷ reported a survey of four public high schools revealing that 50 percent of the teachers and 38 percent of the students reported being victims of a school-based crime during the year. The overrepresentation of urban black students was evident in this

report as well. Black students were suspended at the rate of 17 per 100, compared to a rate of 8 per 100 for white students. A large number of the suspensions (30 percent) are for interpersonal violence.

Weapon-carrying behavior was also reported in this Boston survey. Seventeen percent of the girls and 37 percent of the boys reported bringing a weapon to school at some point during the school year.

Socio-economic factors are thought to account for this overrepresentation of blacks among homicide victims. In a recent Atlanta study data that was corrected for socio-economic status, using the number of people per square foot of housing, no longer showed a racial bias.⁸ Urban black adolescents are overrepresented among the poor with unemployment rates of 40-60 percent⁹ and are overrepresented among the victims of fatal and non-fatal violence.

The severity and urgency of the problem for urban black communities dictates the need for appropriate and effective prevention strategies. The possibilities for such prevention strategies were greatly enhanced by the recent conceptualization of interpersonal violence as a public health problem.

Traditionally violence was viewed as only a law enforcement problem which limited both the professional expertise and the variety of institutions involved. The traditional public health model attributes occurrence of disease to complicated interactions between the environment, the pathogen (the agent that is responsible for the disease), and the host (the individual with the disease). The traditional public health model has been applied to unintentional injuries. The application of the model to violence prevention offers a particular challenge because of the intentional nature of violence-related injuries.

The public health interventions applied to other problems that have been most successful are those that have manipulated the environment and have had little dependence on changes in human behavior. Yet, when applied to intentional injury, environmental manipulations can be expected to be less effective. For example, a safety lock on the trigger of a handgun could be expected to prevent handgun-related accidents; but this intervention could not be expected to have that same effect on intentional shootings.

Altering the host (victim) and the pathogen (assailant) in this case to prevent interpersonal violence and homicide is dependent on changing human behavior, which is more difficult than altering the environment. The goal in such manipulations is to make the host more resistant to the disease, and the pathogen less virulent. Preventing interpersonal violence in urban young black men requires an appreciation of the distinct similarities between the victim and the assailant, as demonstrated by Ruth

Dennis, Ph.D.¹⁰ Her work compares three groups of black men ages 18-34 who were 1) incarcerated homicide perpetrators; 2) victims of serious assault (knife and gun wounds); and 3) randomly selected non-institutionalized black men found through household sampling. Social and psychological profiles of each participant were done and the three groups were then compared.

The victim and perpetrator groups were similar to each other; they were distinguishable from the control group in that they had less education, had experienced more juvenile detentions, were more likely to carry a gun, and were more likely to have been in jail before. In addition to having similar characteristics distinct from the control group, these two groups had more participants exchange roles (victim vs. perpetrator) during the study. Because of this role exchange and the similarities between victim and perpetrator, when the public health model is applied to interpersonal violence the host and the pathogen become equal, and prevention strategies designed to make the individual less likely to be involved in violence are applicable to both.

These strategies designed to raise an individual's threshold for violence are predominantly education and behavior modification techniques. Teaching conflict resolution and using role play to practice alternatives to violence are such strategies.

The tenuous application of the host, pathogen, and environment disease model is not the most significant gain from the conceptualization of interpersonal violence as a public health problem. Perhaps the most significant gain is the potential application of a multi-institutional and interdisciplinary model which has been applied to other public health initiatives. The national campaign to reduce smoking is an example of such an initiative. The media, health care institutions, public schools, job sites, health fairs, and county fairs become the source of education, information, and incentives. Product labeling and advertisement restrictions are a part of the effort. This approach is applicable to interpersonal violence prevention as well when it is understood as a public health problem. Health education programs like the one I teach are only a piece of the total picture.

The Black Adolescent

Designing violence prevention strategies that are effective with urban black adolescents of lower socio-economic status requires an understanding of adolescence, of issues of race, and of poverty. I will not review all the theories of adolescent development under the impact of race or poverty as

such, though I will offer a general outline of these issues as applicable to the development of violent behavior.

Adolescence is that period of dynamic physical and psychosocial maturation which is the transition from childhood to adulthood. The physical changes are the growth and development of puberty. The psychosocial changes include both cognitive maturation from concrete to abstract thinking and the mastering of specific developmental tasks. These are the major developmental tasks:

- 1) Individuation from family with the development of same-sex and opposite-sex relationships outside the family.
- 2) Adjustment to the physical changes of puberty with the development of a healthy sexual identity.
- 3) Development of a moral character and a personal value system.
- 4) Preparation for future work and responsibility.

Failure to accomplish these tasks can result in significant dysfunction for the adolescent, which can impair him as an adult. The tasks are accomplished simultaneously and are the major requisites for healthy adulthood. The experience of poverty and of racism can significantly hinder the accomplishment of these essential tasks. The development of a healthy self-identity requires a sense of self-esteem and a healthy racial identity, both of which can be undermined by poverty and racism. Preparing for future work and responsibility is a meaningfulness enterprise, when unemployment rates are astonishingly high. Developing a sense of moral character and a functional personal value system is also not easy, when television and the street are the main sources of values.

What Is "Normal?"

One of the most difficult problems facing service providers for adolescents is that of defining normal behavior. Normal behavior for adolescents includes a variety of experimental behaviors which at other developmental stages would be abnormal. Defining normal is even more difficult in cases where there is a subcultural experience. Claude Brown in his literary work *Manchild in the Promised Land* describes such an experience:

"Throughout my childhood in Harlem, nothing was more strongly impressed upon me than the fact that you had to fight and that you should fight. Everybody would accept it if a person was scared to fight, but not if he was so scared that he didn't fight."

The example clearly illustrates the dilemma. How much fighting is too much? When is it problematic? Many would agree that violence in self-

defense is appropriate; yet, if a homicide results, would running not have been a better response? On the other hand, in a violent world, is it not healthier to defend oneself rather than be beaten or harassed?

Narcissism and Sexual Identity

There are several characteristics of adolescence which make a teenager more prone to violence. One such characteristic is narcissism. Narcissism helps the adolescent make the transition from family to the outside world. Yet, this narcissism is also responsible for the extreme self-conscious feelings of adolescents which make them extremely vulnerable to embarrassment. The adolescent feels that he is always in the limelight and on center stage. He is particularly sensitive to verbal attack, and it is nearly impossible for him to minimize or ignore embarrassing phenomena. Another adolescent characteristic that predisposes to violence is the transient stage of extreme sexual identity, or "macho." Establishing a healthy sexual identity requires transient stages of extreme femininity for girls and macho for boys. Macho is often synonymous with violent. The image of a coward is a deadly one for a male adolescent in this stage.

Peer pressure has been labeled the single most important determinant of adolescent behavior.¹¹ This vulnerability to peer pressure, a normal part of adolescence, facilitates the accomplishment of several of the developmental tasks; yet, it is a characteristic of adolescence which enhances the predisposition for violence. If fighting is the expectation of peers, as illustrated in Claude Brown's quote, then an adolescent is often unable to disregard those expectations.

Erikson¹² describes a societal moratorium from responsibility that is necessary during adolescence to allow the requisite experimental behavior to occur without compromise of future options. Thus, the adolescent is able to experiment with a variety of roles without making a commitment. There is debate as to whether this moratorium occurs at all, yet many agree that in the situation of poverty, it does not. The poor adolescent struggles with developmental tasks without the protection of a societal moratorium.

The black adolescent has to develop healthy racial identity, in addition to the listed developmental tasks. Contact with racism results in anger that appears to contribute to the overrepresentation of black youth in interpersonal violence. Psychologist Ramsey Lewis used "free floating anger" to describe anger not generated by a specific individual or event but from global factors such as racism and limited employment options.¹³ This anger is the excess baggage that an individual brings to an encounter that lowers

his threshold for directed anger and violence. This concept is helpful in that it attempts to account for the environmental and socio-economic factors and not label the individual as deficient. The anger is normal and appropriate. Violence prevention is therefore designed to achieve a healthier response to anger, not to eliminate the anger itself.

Violence prevention programs which are appropriate for adolescents developmentally and which have a realistic cultural context can be expected to be effective. Developmentally appropriate programs utilize peers in education and counseling and reflect an understanding of the stages of adolescent development. The cultural context has to acknowledge the violence, racism, and classism that many such adolescents experience.

The problem of interpersonal violence among poor black adolescents has been long appreciated by frontline service providers, and despite an incomplete understanding of the causal factors, prevention and intervention programs have been developed with moderate success. The majority of these prevention programs are either based in a school or linked to a school because of the captive audience. Most are interdisciplinary and multi-institutional.

The Boston Curriculum

The Boston Youth Program is a comprehensive health care initiative for adolescents funded by the Robert Wood Foundation¹¹. The health care services are hospital- or clinic-based and the health education/prevention services are school-based. A violence prevention curriculum developed for tenth-grade health students is one of the health education services. The Boston Youth Program curriculum on anger and violence has been instituted in four Boston high schools and one community agency setting. To date, approximately 500 students have received the curriculum. The curriculum is designed to

- 1) provide statistical information on adolescent violence and homicide;
- 2) present anger as a normal, potentially constructive emotion;
- 3) create an awareness in the students for alternatives to fighting by discussing the potential gains and losses from fighting;
- 4) have students analyze situations preceding a fight and practice avoiding fights by using role play and videotape;
- 5) create a classroom ethos which is non-violent and values violence prevention behavior.

The prevention curriculum is specifically aimed at raising the individual's threshold for violence, by creating a non-violent ethos within the classroom

and by extending his repertoire of responses to anger. It acknowledges the existence of societal and institutional violence and the existence of institutional racism. Students are not taught to become passive agents, but they are expected to claim anger and become intentional and creative about the responses to it.

Anger is presented as a normal, essential, and potentially constructive emotion. Creative alternatives to fighting are stressed. The classroom discussion during one session focuses on the good and bad results of fighting. The students list the results. The list of bad results is invariably longer than the good list; thus, the need for alternatives. This exercise emphasizes that fighting or not fighting is a choice and that the potential consequences are important to consider when making the choice.

Role-playing a fight is a unique part of the curriculum. During this session the students are asked to create a usual fight situation. The fight is videotaped and analyzed for the buildup or escalation phase, the role of the principal characters, and the role of the friends in the crowd. Videotaping the role-play is useful for discussions. Provocative behavior is labeled and alternative behavior is discussed. The focus of the discussions is the demonstration and reinforcement of preventive behavior.

The 10-session curriculum has been evaluated using pre- and post-testing in one of the high school settings.¹² This controlled study involved four tenth-grade health classes of 106 students (approximately one-third of the 10-grade enrollment for the school). Two classes were assigned to the experimental group, while the other two classes were the control. The violence prevention curriculum was presented to the experimental group, while the control students continued with the regular health curriculum. Both groups were evaluated by the same pre- and post-test instrument approximately 10 weeks apart. The instrument tested for both knowledge and attitudes about anger, violence, and homicide.

Higher Post-Test Scores

The experimental group had significantly higher post-test scores than the control group. There was no difference between the pre-test scores for the two groups. Knowledge scores accounted for more of the change than did the attitude scores, though the change in attitude was significant with $P < .01$. These differences in scores represent the effect of the Violence Prevention Curriculum.

Student questionnaires were used to evaluate the curriculum. Eighty-seven percent of the students enjoyed or very much enjoyed the unit.

Seventy-three percent of the students found it helpful with handling depression, and 63 percent found it helpful in handling anger.

This demonstration project shows that students can be receptive and enthusiastic about a curriculum on anger/homicide, and that a significant impact on both their attitudes and their knowledge can be accomplished. Further study must delineate the impact this curriculum has on behavior and the longevity of the impact. These preliminary results indicate that health education as a technique for violence prevention should be studied further and that no harm is apparent from the effort.

Recommendation

I believe that a health education initiative ought to be part of a national campaign to reduce interpersonal violence. Such an initiative could use a standardized version of our curriculum, replicated in a variety of high schools across the country. It would involve some teacher training and the production of new audiovisuals. If possible, some sort of nationwide, large-scale evaluation could be carried out, using pre- and post-testing for knowledge, attitudes, self-report of behavior, and self-concept. In addition, we would want to measure the longevity of the impact and the impact on behavior.

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This Epidemic of Family Violence

Presented by Anthony V. Bouza
Chief of Police, Minneapolis, Minnesota
Monday morning, October 28, 1985

In our society the family has been the traditional source of strength and stability. This sense of family was part of every immigrant group to these shores, from the first groups, the English and the Spanish colonists, to the most recent groups, such as the Central Americans and the Southeast Asians. But we are beginning to get an idea that not all families are strong and stable. In some, there may be abuse of one or another member, the wife or the children or an elderly parent. There may be incest. All these kinds of actions are crimes of violence. The outcomes involve pain and great personal distress. But these abuses and acts of violence against children also endanger society, since they are, in effect, acts that create tomorrow's adult criminal.

This is particularly and painfully evident among teenage women who become pregnant and have their babies, using them as a kind of ticket out of the house and into the adult world. They are "children having children," and a great many of them simply can't handle it. Already the reports are beginning to multiply of teenage mothers who have abused, severely beaten, and even killed their babies during periods of depression or anger or frustration. Of the babies that survive, many grow up to be the abusers and killers of tomorrow. And thus is born the generational cycle of family violence.

Some people use the term "monsters" to describe these babies who grow up as sociopaths, a menace both to the community at large and to those immediately around them. But I submit that the real "monster" in our society may, in fact, be that teenage mother, who bears her child and raises it, but is incapable of giving it a decent, peaceful family life, a life enriched by mutual love and a mutual sense of responsibility. Instead, these are children bred in chaos and violence; and they, in turn, breed their own chaos and violence.

This development — or this revelation — of violence in the American family, and outward from the family into the community, has had a profound impact on women in our society. Once placed on a pedestal and virtually worshipped, the American woman has been pulled off that pedestal

to become the target of street predators: muggers, rapists, and "Johns." They prowl at night, a time which no longer can belong to a woman alone. The appetites of these predators are whetted and twisted by the pornography industry, which is now doing billions of dollars worth of business in every medium of communication, including telephone and cable television. Women are enlisted or forced to take part in this industry, beginning with prostitution. Most of the time, they are snared into the business as teenage runaways. They have usually fled the sexual exploitation that begins right in their own homes, where they are victimized by members or close friends of the family . . . by fathers, step-fathers, brothers, and "uncles," real or imagined. For too many girls, this victimization occurs before they are 12 years old. Once on the street, their flesh is bartered over and over again, for years, until they have no sense of who they are, who they could have been, or even who they might still be.

For women, the issue of control of their own bodies is critical, but it is not an issue only for the prostitute or for the sexually victimized woman. Among women with more socially acceptable careers or with families, the issue re-appears as the abortion issue or as the marital rape issue. As suggested by the title of the best-selling book on women's health, "Our Bodies, Our Selves," if a woman does not control her own body, how can she have control over her self-hood and her destiny? She can't. Once she loses control over access to her own body, the cycle of abuse and violence only gets worse. Prostitution escalates to disfigurement and rape, and assaults escalate to homicide, the ultimate and total denial of a woman's body and self.

"Mad as Hell"

But women are fighting back through the feminist movement and the drive for liberation. They are raising their own consciousness and the consciousness of others, too. They are "mad as hell and they aren't going to take it anymore" and they have vowed to "take back the night." Their enemies are rape and pornography, which imprison women in a hopeless cycle of abuse, degradation, victimization, and death. Dozens of new women's organizations have sprung up representing virtually every point across the spectrum of health and justice, of politics and society. New institutions, such as women's shelters, have become integral elements of the total human resources of a community.

A year ago, in September 1984, the Attorney General's Task Force on Family Violence published a report which gave strong support to any efforts

that could change the way police departments look at family violence. The Task Force said that violent acts within a family are still criminal acts and they must be treated as crimes. The victims must be protected and given justice. The perpetrators must be arrested. The report indicated — and I agree — that arrest is still our best leverage for correcting a situation, including bringing the perpetrator into some kind of treatment.

For a woman, the arrival of the police is the time when she must bite the bullet. She has to understand how our adversarial system of justice works in order to take full advantage of it. For centuries women have been raised to accept their fate as victims and therefore to think and act like victims. If they were abused, they were led to believe that they somehow "deserved" it. But those days have got to end for all women. And they, in turn, need understanding and compassion from the police and the courts. They need strong advocates. But no one is more powerful than a woman herself. The woman/victim must use the system, must file a complaint, and, the hardest part of all, she must come forward to testify.

Male Myths

For their part, the police and the criminal justice system must abandon their convenient myths of male authority and power and must begin to take seriously the woman who lodges a complaint against a batterer. Yes, the police are changing, but they are still not effective in countering the arguments and pleas of the batterer and the abuser. We've heard those arguments a million times: that a man's home is *his* castle, not hers; that she must've done something to deserve what she got; that she probably "had it coming to her;" that they always kiss and make up; and they'll have forgotten all about it by morning. Sure, she filed a complaint, but we'll hold off signing it and see if she works things out like the others usually do. And so on.

Today's police need to adopt policies which limit discretion to allow this kind of thinking, policies which compel the arrest of the perpetrator or, if there is no arrest, policies which require a report explaining exactly why. The same thing applies to prosecutors and the courts. They, too, must begin to treat this matter seriously, applying sanctions of every kind to change the dangerous behavior of the batterer or the abuser and to protect the life and health of the victim. Parole and probation officers must recognize domestic violence as a crime and, therefore, a violation of the terms of probation or parole. And we need a re-evaluation of existing law, with new provisions making it harder for the batterer to get away with threats

and intimidation. These and other psychological weapons can be as destructive to a woman as physical punishment itself.

The demonstration project in domestic abuse, which we conducted in Minneapolis, revealed several things. First, we learned how important it is for a woman victim to be helped very early in the process by a woman's advocate. If they can be helped through those first few hours of horror and trauma and confrontation, most women will then show the courage and the intelligence to get protection and justice. We also became true believers in the importance of the women's shelter. There had to be a secure place to run to, a place where a woman will be understood, a place that doesn't ask a lot of questions because all the questions have already been asked and answered by the people already there to take her in.

Alcohol and Drugs

We also learned never to underestimate the possible role of alcohol and drugs. Alcohol and drugs in a man's bloodstream will take the place of love and reasonableness and responsibility and the healthy fear of unknown consequences. And we learned that the best weapon in our arsenal is the weapon of arrest. Get the perpetrator out of the situation, release the victims — his wife, his children — from the prison of his terror. Dry him out. If he's got a chronic abuse problem, get him into treatment.

That's where the medical profession comes into play. The police can't do this job alone. We know that. The courts can't do the job alone. They know that. We need the help of people like the ones here at this Workshop . . . doctors, nurses, psychiatrists and psychologists, social workers, lawyers, counselors . . . you are the people who can step in and treat and prevent and protect. You are the ones who can help a woman and her children rebuild their lives. Otherwise, the cycle of violence in that family will continue to escalate. And finally someone will get killed. The death of the victim — spouse, child, or parent — is the ultimate "kick," the final degradation.

The new federal and state laws requiring the health and social service professions to report any actual and *suspected* cases of abuse have been a long time in coming. But now they're here, and I urge every member of those professions to obey those laws, to report what they may believe to be the abuse of a child or the victimization of any member of a family by any other member. Such acts are crimes. Report them.

Violence of all kinds is reaching epidemic proportions in our society. We've got to work together to fight back, because we will never have

enough police and judges and jails to stem the rising tide of violent crime. Prevention is the only answer. But prevention comes in a variety of forms:

- It involves treatment for physical and mental health.
- It involves helping a person break away from a dependence on alcohol and drugs.
- It involves social justice — better schools, safer housing, more jobs for disadvantaged youngsters.
- It involves controlling the instruments of violence, such as handguns.

This may not be an issue that would ordinarily involve the Surgeon General; nevertheless, while we're here together focusing on violence, I must ask him to use whatever influence he may have to convince the President and other members of the Administration to work for the total outlawing of handguns.

More Research Needed

Finally, I want to encourage the people here and anyone else who hears of this Workshop, that this is an area that still needs a great deal of research. We have relatively few facts; what we have most are statistics, and those are mainly drawn from arrest records and court records. But we don't know enough about why domestic violence occurs or who the typical offenders and perpetrators are. Until we get a more substantial body of research data behind us, we're not going to be able to do an effective job of treatment and prevention. And by "we" I mean not only the police departments of our country, but also the courts and the hospitals and the family service agencies and the churches and all the different community agencies, public and private, that can provide a healthful, positive influence upon the course of American family life.

This Workshop is a very important undertaking by the Surgeon General and I commend him and the U.S. Public Health Service for having taken the initiative and doing it. I can assure you that this effort comes not a moment too soon.

Thank you.

Plenary Session IV

Recommendations of the Work Groups

Tuesday afternoon, October 29, 1985

ASSAULT AND HOMICIDE: EVALUATION AND TREATMENT

CHAIR: Fernando A. Guerra, MD, MPH
ADVISORY COMMITTEE MEMBER: David Nee
RECORDER: Deborah Stevens
PARTICIPANTS: David A. Heppel, MD
Capt. Bartholomew T. Hogan, MC, USN
Thomas L. Lalley
Charles S. Petty, MD
Deborah Prothrow-Stith, MD
Susan E. Salasin
Jose M. Santiago, MD
Marlene A. Young, PhD

Members of this work group introduced their recommendations with the following preamble:

- Violence in the United States has become so pervasive that it can no longer be usefully viewed only as a problem of disparate acts by individual offenders. Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among young people.

- Public health has continually redefined its role so as to address more effectively the changing needs of a changing nation. Public health now needs to accept the challenge presented to our country by violence and its consequences.

- Any solution to the problem of violence will require a total community effort, in which health care providers can play a special role. The emergency room is often the first contact a victim has with those professionally charged to provide health care. That encounter may determine how well a victim recovers from the emotional consequences of assault as well as from the physical trauma.

- The health care system must help victims recover emotionally as well as physically and must help prevent further violence. Too many victims are victimized again and again; providers must be alert to the special needs of those most at risk of becoming repeat victims.

- Our call is for a spirit in America that rejoices in our ethnic variety, a spirit that protects all of our people as our most important resource and legacy, and finally a spirit that no longer tolerates violence.

In the area of *Education* we recommend that . . .

- . . . information about the particular needs of violence victims — actual or potential, direct or indirect — and their communities should be part of the education of any health professional who interacts with violence victims. (E-1)

- . . . the Public Health Service should encourage schools of medicine, nursing, social work, osteopathy, and the allied health professions to offer more and better training in the treatment and management of victims of violence. (E-2)

- . . . the Public Health Service and the health professions should encourage state licensure and national board certification authorities to include in their examinations questions related to violence as a health/mental health problem. (E-3)

- . . . leaders in the fields of health and mental health should actively enlist the media, schools, and community agencies in educating the public about violence as a health problem. (E-4)

In the area of *Research* we recommend that . . .

- . . . the Public Health Service should support improvements in the collection of data about direct and indirect victims of assault and homicide, since at present there is so little reliable data on the numbers and types of victims treated by the health care system. (R-1)

. . . the following kinds of research ought to be pursued:

- How is the health care system actually used by victims of violence?
- What are the salient characteristics of assault and homicide victims, and what are the circumstances of each incident?
- What kinds of discrepancies are there between hospital and police reports of assault?
- What kind of risks do assault victims run of eventually being killed?
- How effective are current hospital policies and procedures for identifying, coding, treating, and referring victims of assault?

In the area of *Services* we recommend that . . .

- . . . organizations representing professionals who provide emergency health care, such as the American College of Emergency Physicians, the National Association of Social Workers, and the American Nursing Association, should review concepts and procedures relative to emergency care for victims of violence, with particular attention to improving victim identification, assessment, treatment, and referral. (S-1)

- . . . evaluation and treatment services should be available to both direct and indirect victims of homicide and other violence, including witnesses, care-givers, the victim's family and significant others, and the community. (S-2)

- . . . special attention should be paid to the adequacy and sensitivity of the health care given to young minority men in low socio-economic status who are at greatest risk for homicide and repeated assaults. (S-3)

- . . . every examination of a direct or indirect victim of violence should include a history of past victimization and/or perpetration of violence, the victim's risk profile, and an assessment of his or her total health needs. (S-4)

- . . . a comprehensive, collaborative, community-based approach to victim assistance should be encouraged among health care providers, the criminal justice system, victim service agencies, churches, and other relevant community service organizations. (S-5)

- . . . leaders in health and mental health should support the development of victim assistance programs where they don't exist and the improvement of existing programs that are inadequate. (S-6)

- . . . health care providers should draw upon the experience of victim service agencies in the course of improving their own case management, advocacy, and referral services for victims of violence. (S-7)

- . . . the Public Health Service should help in the review and dissemi-

nation of innovative hospital protocols offering better care for victims of violence. (S-8)

... hospital boards and top administrators should clearly articulate their hospital's policy in the following areas affecting the care of victims of violence:

- a commitment to effective identification, treatment, and referral services;
- a commitment to train staff who interact with direct or indirect victims;
- and the use of multi-disciplinary hospital committees to monitor policy implementation and maintenance of quality care for victims. (S-9)

ASSAULT AND HOMICIDE: PREVENTION

CHAIR: John B. Waller, Jr., DrPH

ADVISORY COMMITTEE MEMBER: Mark L. Rosenberg, MD

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Robert A. Fein, PhD

Karil S. Klingbeil, MSW, ACSW

Dorothy Otnow Lewis, MD

J. Ronald Milavsky, PhD

Robert Ressler

Vicki Weisfeld, MPH

Members of this work group introduced their recommendations with the following statements:

- Our specific recommendations for the health and public sectors are preceded by general policy recommendations that go beyond the health sector.
- The focus on the health sector recognizes the vital contributions health professionals can make without implying that those contributions are any more or any less important than those made by other disciplines.
- We recognize that the Office of the Surgeon General cannot, by itself, carry out all these recommendations, but we nevertheless believe that these policy issues are fundamental to any statement on the prevention of homicide and assaultive behavior.

Therefore, in the area of *Policy* we recommend that . . .

... there be a complete and universal federal ban on the manufacture, importation, sale, and possession of handguns (except for authorized police and military personnel) and that the manufacture, distribution, and sale of other lethal weapons, such as martial arts items, knives, and bayonets, be regulated.

... criminal penalties be levied for possession of any weapon where alcohol is sold or served.

... the public should be made aware that alcohol consumption may also be hazardous to health because of its association with violence.

... a full employment policy should be developed and implemented for the nation, with immediate attention given to creating jobs for high-risk youths.

... there be an aggressive policy to reduce racial discrimination and sexism.

... the cultural acceptance of violence be decreased by discouraging corporal punishment at home, forbidding corporal punishment at school, and abolishing capital punishment by the state — all are models and sanctions of violence.

... that there be a decrease in the portrayal of violence and violent role models on television and other media and an increase in the presentation of positive, non-violent role models.

In the area of *Education* we recommend that . . .

... the education of health professionals should include training in the identification, treatment, and/or referral of victims, perpetrators, and persons at high risk for interpersonal violence. (E-5)

In the area of *Research* we recommend that . . .

... studies should be conducted to examine how current rates of assaultive violence and victimization may be related to the policy of deinstitutionalization of mentally ill persons and the lack of adequate community-based support services for those persons and their families. (R-3)

... development should be encouraged of health education demonstration projects for the family, school, and community aimed at decreasing interpersonal violence and that these projects be evaluated to their effectiveness and replicability. (R-4)

In the area of *Services* we recommend that . . .

... community health care facilities should offer comprehensive, multi-disciplinary programs to detect, assess, and treat victims and perpetrators of all forms of interpersonal violence, as well as to assess and treat family members and individuals at high risk of violence. (S-10)

... health care providers, criminal justice agencies, schools, and social service agencies should communicate and cooperate to a greater extent in order to improve the identification and treatment of — and early intervention for — high-risk individuals. (S-11)

CHILD ABUSE: EVALUATION AND TREATMENT

CHAIR: Howard B. Levy, MD

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Marie Kanne Poulsen, PhD

Johanna Schuchert

George G. Sterne, MD

In the area of *Education* we recommend that ...

... professionals who work with children and their families should be offered — and encouraged to take — interdisciplinary continuing education programs. (E-6)

... schools that prepare professionals to work with children and families should adopt interdisciplinary curricula for clinical as well as classroom instruction in the prevention and treatment of child abuse; persons from all involved disciplines should share in presenting these curricula to students. (E-7)

In the area of *Research* we recommend that ...

... local, state, and federal agencies should design and fund child abuse research and treatment, utilizing a public health perspective. (R-5)

... individual communities should establish their own multi-professional "commissions" to assess both harm and benefit to child abuse victims resulting from criminal prosecution and disposition. (R-6)

... a major longitudinal/epidemiological study should be mounted, similar in purpose and scope to the Framingham and Cambridge studies, documenting prospectively at least 30 years' experience in the causes, consequences, and nature of child abuse and responses to it. (R-7)

In the area of *Services* we recommend that ...

... child protection services and other agencies should expand the range of both long-term and intensive short-term treatment alternatives for families in need, using such modalities as medical services, family support, and parent/adult aides. (S-12)

... visiting nurses, attending physicians, and other professionals should make their own services more readily available for abused children and their families, allowing Child Protection Service agencies to focus on the more serious incidents of abuse and on the children at highest risk. (S-13)

... every hospital should have an interdisciplinary child protection team that can care for all the child's and family's needs at one site and within a minimum number of visits. (S-14)

... standards of health care for abused infants and children should include immediate and complete physical and psychological assessments; competent and continuous care should be provided for any problems uncovered in these assessments. (S-15)

CHILD ABUSE: PREVENTION

CHAIR: Douglas A. Sargent, MD, JD
ADVISORY COMMITTEE MEMBER: Georgia K. Millor, RN, DNS
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Col. Jesse Harris, DSW
LaVohn Josten, RN, PhD
Blair Justice, PhD
David M. O'Hara, DASS
Barbara Rawn
Reymundo Rodriguez
Gloria Smith, PhD
Robert L. Stein II

In the area of *Education* we recommend that . . .

- . . . public awareness should be dramatically increased regarding the nature and extent of child abuse, with emphasis on the fact that child abuse is not limited to physical and psychological abuse but also includes abusive neglect, poverty, and other social injustice. (E-8)
- . . . a major campaign should be carried out, with the help of the media, to reduce the public's acceptance of violence in general and violence against children in particular, including physical punishment (a campaign could use a variety of techniques, such as declaring a "No Hitter Day"). (E-9)
- . . . the American people should come to understand and agree that corporal punishment of children should be abolished. (E-10)
- . . . planning for pregnancy ought to be seen as the starting point for the prevention of child abuse and other forms of child maltreatment by new and/or young parents. (E-11)
- . . . education for parenthood should be more widely promoted and supported so that it may be made available to all prospective and current parents. (E-12)
- . . . public health departments and public hospitals and clinics should

provide educational and support services for parents and families, including appropriate cultural and linguistic services for particular ethnic and minority groups. (E-13)

In the area of *Research* we recommend that . . .

- . . . studies should be done to identify what makes abusive families different from non-abusive families. (R-8)
- . . . we need to learn more about the ways various ethnic and racial groups define "abuse." (R-9)
- . . . we learn more about the impact that changes in public policy make upon the family. (R-10)
- . . . further development and testing should be done of explanatory and predictive models for maltreatment causality. (R-11)
- . . . more multi-disciplinary longitudinal and cross-cultural research be carried out to evaluate the impact of violence prevention programs on individual children, families, communities, and ethnic groups. (R-12)
- . . . the Epidemiology of Violence Branch of the PHS Centers for Disease Control ought to focus more attention upon child abuse and maltreatment. (R-13)

In the area of *Services* we recommend that . . .

- . . . as a public health priority, families should be provided with vital services, such as home visitor services, for the health and welfare of vulnerable children. (S-16)
- . . . priority services — including treatment and rehabilitation — should be provided to children who are at highest risk to be abused, such as developmentally disabled children, runaways, and children of parents who are at highest risk to be abusive, such as prison inmates, teenage mothers, mentally retarded or otherwise mentally impaired parents, substance abusers, homeless parents, and parents who themselves had been abused as children. (S-17)
- . . . the kind of quality child care that promotes healthy child development should be available to all families. (S-18)
- . . . those services that prevent undesired pregnancies should be generally available. (S-19)
- . . . children identified as being at greatest risk for abuse should be afforded linguistically and culturally appropriate services for the prevention of child abuse. (S-20)
- . . . alternatives to abusive behavior should be widely offered, such as training in conflict resolution, anger control, and stress management

and other programs in behavioral change like those offered by self-help groups. (S-21)

... a national public health resource center ought to be established to train and otherwise assist professionals working on the public health aspects of child maltreatment; this center would also cooperate with social service, legal aid, and other types of resource centers dedicated to child abuse. (S-22)

CHILD SEXUAL ABUSE: EVALUATION AND TREATMENT

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In the area of *Education* we recommend that ...

... a core curriculum in child sexual abuse should include strategies for identifying, reporting, assessing, treating, and referring victims and should be a required part of the professional education of all child abuse reporters mandated under state law, such as physicians (especially those in emergency medicine and pediatrics), psychiatrists, psychologists, nurses, mental health workers, dentists, social workers, teachers, law enforcement personnel, and clergy. (E-14)

... professional schools and organizations, certifying boards, and institutional accrediting bodies should cooperate in the development and implementation of a core curriculum in child sexual abuse. (E-15)

... health, mental health, and criminal justice professionals providing direct service to victims of child sexual abuse need to be trained in (and made sensitive to) normal child development, cross-cultural differences, the special vulnerability of handicapped children, and the many legal and forensic issues in this area; they also need to be trained in the problem of trauma contagion, which can cause staff burnout and victim re-traumatization. (E-16)

In the area of *Research* we recommend that ...

... a national child sexual abuse research and information center should be established to provide computerized data about funding, ongoing research, treatment programs, assessment protocols, and training and educational materials for workers in this field and for families of victims. (R-14)

... a centralized information point within the Department of Health and Human Services, preferably the Centers for Disease Control, should be established and made responsible for aggregating, standardizing, and transmitting case report data; for collecting and analyzing violence-related data from the FBI, the National Center for Health Statistics, and the National Institute of Justice; and for conducting surveys of practitioners, institutions, and the public in order to define and report annually on the incidence, prevalence, time trends, and geographic distribution of child sexual abuse. (R-15)

... studies should be carried out of the short- and long-term impact of sexual abuse on infant and child victims, with particular attention to children who are physically, emotionally, or developmentally impaired; who are victims of extreme abuse; who have minimal family or other support, particularly children requiring placement; and who have extensive and intrusive legal problems. (R-16)

... baseline data need to be gathered — through standardized tests, structured interviews, and genital examinations — to determine genital and psychosexual development among non-abused children for comparison with data from sexually abused children. (R-17)

... research should be conducted that leads to the further development of such specialized instruments as symptom checklists, developmental assessments, projective tests, structured interviews using anatomically

correct dolls, coloring books and drawings, and structured family assessments. (R-18)

... more studies in treatment outcomes should be conducted, particularly in the following areas:

- What happens when either the perpetrator or the victim in an intra-familial case of child sexual abuse is removed from the family?
- How effective are individual, group, and family treatment programs involving sexually abused children?
- What strategies — legal, home care, or patient advocacy, for example — will bring into treatment the families of sexually abused children? (R-19)

In the area of *Services* we recommend that ...

... the assessment of a victim of child sexual abuse and his or her family should be done by mental health and other experts as part of a multidisciplinary team, with the primary goal being a treatment and intervention plan for both victim and family to be carried out with community resources. (S-23)

... each disclosure of abuse should lead to only one assessment before a treatment plan is created and the clients — victim and family — are referred to community resources. (S-24)

... assessments should be done with standardized protocols for four axes (physical health status, mental health status, family and environmental factors, and the investigatory/legal situation), with additional axes of assessment incorporated as they emerge from protocol research. (S-25)

... the California protocol for the physical examination of sexually abused children should be considered a model, as it also specifies facility standards, forensic tests, and laboratory tests for the presence of sexually transmitted diseases (and contact testing, when positive). (S-26)

... the assessment process should explore the possibility that other members of the victim's household have experienced childhood sexual abuse or other forms of family violence. (S-27)

... the assessment process — with the aid of standardized forms, one-way mirrors, a minimum number of designated examiners, video- and/or audiotaped interviews, photographs, and careful scheduling — should keep to a minimum the need to re-interview, re-examine, and re-traumatize the child and the family. (S-28)

... consultations and second opinions should be rendered, whenever possible, on the basis of a review of documents and a discussion with

the original interviewing team, rather than on a re-examination and/or a return interview. (S-29)

... specialized, comprehensive intervention should help the entire family and/or substitute family understand what happened, acknowledge their feelings, explore their fears, and separate past from present coping mechanisms. (S-30)

... the goals of intervention should be to reduce symptoms, to enhance the individual's and family's ability to adapt positively to the situation, and to promote the growth and development of each child. (S-31)

... the treatment program for the victim of child sexual abuse should begin immediately and continue according to a plan which is rewritten as the child's needs evolve. (S-32)

... regional resource centers should be developed to offer treatment consultation for difficult cases, especially in medically underserved areas, and to guide new self-help groups, to gather data, to coordinate regional, legal and social service providers, to train workers, and to provide other kinds of educational assistance. (S-33)

CHILD SEXUAL ABUSE: PREVENTION

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Members of this work group introduced their recommendations with the following set of background assumptions:

- Abuse is everyone's business. The health, mental health, and economic costs associated with abuse affect all Americans now and in the future.
- Prevention is directed both at the *public* and at the *targeted groups at high risk* for sexual abuse.
- *Primary* prevention of child sexual abuse concerns stopping abusive behavior before it occurs; *secondary* prevention concerns early identification and treatment of the victim of abuse.
- Culturally sensitive approaches must be integral to all recommendations.
- American society must realistically confront the phenomenon of child sexual abuse.
- Our first priority must be to protect the child.

In the area of *Education* we recommend that . . .

. . . an aggressive public education campaign, emphasizing sexual abuse as a harmful and criminal act, should be carried out with the objective of stopping the sexual abuse of children. (E-17)

. . . the public should be given the facts about child sexual abuse and the options available for prevention and treatment. (E-18)

. . . core curricula for undergraduate, graduate, and continuing education programs for health and human service professionals should incorporate authoritative, appropriate material on child sexual abuse, including material on prevention and techniques for intervention. (E-19)

. . . educators, parents, and public health officials should provide all children, from elementary school on, with well-evaluated materials on the prevention of child sexual abuse, including (at a minimum) material on sexual abuse, appropriate and inappropriate touching, the right to say no to inappropriate touching, appropriate and accurate sexual terminology, and the importance of telling someone when sexual abuse occurs. (E-20)

. . . educators, parents, and public health officials should design, test, and put into their elementary and secondary schools programs that teach effective parenting skills and child development, in order to foster a new generation of parents better able to prevent — and less likely to perpetuate — the sexual abuse of children. (E-21)

In the area of *Research* we recommend that . . .

. . . a national search should be carried out to identify, evaluate, highlight, and disseminate information about effective primary prevention programs for child sexual abuse. (R-20)

. . . the research agenda should be expanded along the following lines:

- gaining more specific knowledge of the incidence and prevalence of child sexual abuse among specific segments of the population;
- conducting prospective longitudinal studies in order to document and better understand the short- and long-term effects of disclosed and undisclosed child sexual abuse;
- identifying high-risk children and families and delivering preventive educational programs to them;
- evaluating a broad range of preventive educational programs;
- identifying normal sexual development and behavior in order to more accurately identify deviant development and behavior;
- identifying the characteristics of men who are serious, repetitive perpetrators of child sexual abuse;
- examining the role of parenting behaviors and the degree of involvement of fathers in order to provide insight and to reduce their risk of being sexual abusers of children;
- understanding the potential for further harm to a child as a result of the disclosure of having been sexually abused and of the child's subsequent involvement in the criminal justice system. (R-21)

In the area of *Services* we recommend that . . .

. . . key community, government, public health, and media and advertising professionals should work together to establish policies and to encourage public and private initiatives for setting limits on the sexualization of children in the media and advertising. (S-34)

. . . better coordination should be accomplished among federal, state, and local programs, policies, and activities in law enforcement, prosecution, defense, social service, criminal and juvenile justice, and public health in order to improve the identification and prevention of child sexual abuse. (S-35)

. . . programs should be strengthened and expanded serving runaway and homeless youth, since they are at high risk for sexual exploitation.

. . . public/private partnerships and community-level cooperation ("networking") among family and youth services should be increased. (S-37)

. . . federal, state, local, and private financial resources should be in-

creased to support programs that might effectively reduce the incidence of child sexual abuse. (S-38)

ELDER ABUSE: EVALUATION AND TREATMENT OF VICTIMS AND PREVENTION

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Members of the work group on elder abuse said the following assumptions are basic to their recommendations:

- Competent older persons have the right to self-determination.
- No group is immune to elder abuse; the problem cuts across all social classes and all racial, ethnic, and religious groups.
- Most older people live independently, while others live happily and safely in the care of or in the homes of others; many American families are heroic in the care they provide elderly relatives.
- Elder abuse is, in many instances, a result of the ageism prevalent in our society.
- Elder abuse is part of the larger social problem of violence in contemporary American life.

In the area of *Education* we recommend that . . .

. . . health care providers, social service agencies, and criminal justice professionals should receive education and/or training in the detection, assessment, and treatment of elder abuse. (E-22)

. . . educational programs should be developed to increase public understanding of elder abuse. (E-23)

. . . community educational and outreach programs should be developed to help older people protect and take better care of themselves and to make use of community resources. (E-24)

. . . educational programs should be developed to illustrate the potential for family violence throughout the life cycle and for the prevention of such violence. (E-25)

In the area of *Research* we recommend that . . .

. . . national studies should be carried out on the incidence, prevalence, dynamics, and outcomes of elder abuse. (R-22)

. . . studies should be conducted to determine the effectiveness of programs to prevent, detect, treat, and control elder abuse. (R-23)

. . . items regarding elder abuse should be added to existing public health surveys, such as the National Health Interview Survey and the National Health and Nutrition Examination Survey. (R-24)

. . . there be a national elder abuse clearinghouse for coordinating research, training, and program development in the public and private sectors. (R-25)

In the area of *Services* we recommend that . . .

. . . services to elder abuse victims should include legal assistance, victim advocacy, emergency and long-term housing, and other services that help ensure the rights of older people to be independent and live free from abuse. (S-38)

. . . additional services, such as respite care and adult day-care, should be made available to help families care for members who are elderly and vulnerable. (S-39)

. . . the criminal justice system should be better equipped to respond, in cooperation with other agencies, to the problem of elder abuse. (S-40)

. . . such community coordinating mechanisms as case identification, case management, crisis intervention, and communication linkages should be developed and expanded to address the problem of elder abuse. (S-41)

RAPE AND SEXUAL ASSAULT: EVALUATION AND TREATMENT

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Members of this work group introduced their recommendations by listing these background issues:

- The general public, families of victims, and providers of human services will only further victimize rape victims if they continue acting on the basis of commonly held but mistaken myths and biases concerning rape, or bringing insufficient knowledge and skill to the task of caring for rape victims, or failing to accept a more responsible role in the evaluation and treatment of victims. Rather, the community and its service providers must respond on the basis of the facts of rape and sexual assault.
- Rape is a crime of violence. It is not primarily a sexual act, whether it occurs between strangers, acquaintances, or intimates. However, a rape victim may have difficulty later experiencing normal sexual and other interpersonal relations.
- Rape is rarely the act of a psychotic person. Rape is a criminal expression of power and domination inflicted primarily by men upon women, although some victims are also men.
- Sexual violence is behavior learned from various sources, such as the mass media, pornography, childbearing experiences, and family violence.
- Sex role stereotyping supports the unequal power relationships between women and men. Traditional male socialization limits men's ability to express tenderness and encourages their use of violence to resolve conflicts rather than the use of communication and negotiation.

- Women have the right to say no and to have their refusal respected.
- Violence must be eliminated as a means of resolving conflict.

In the area of *Education* we recommend that . . .

. . . a nationwide public education campaign should be carried out giving the facts about violence, sexual assault, and rape, including information describing the type and extent of service a victim should expect to receive. (E-26)

. . . professionals involved across a wide spectrum of health, human service, and criminal justice activities — persons most likely to have contact with rape victims — should be given information concerning the evaluation and treatment of rape victims in basic professional preparation and continuing education programs. (E-27)

. . . mental health professionals should take the lead in assuring the relevance of their own education concerning sexual violence before offering consultation services to police, educators, and others. (E-28)

. . . the planning for public education programs to correct the myths and biases concerning rape ought to be carried out with an understanding that the information will also be reaching and influencing health and human service professionals as well. (E-29)

In the area of *Research* we recommend that . . .

. . . there be training programs specifically to prepare professionals to conduct research in the area of rape and sexual assault. (R-26)

. . . the following research areas ought to be pursued:

- the epidemiology of rape;
- the social environment of rape and sexual assault;
- the types and effects of various intervention strategies;
- the longitudinal pattern of recovery by victims and significant others from sexual assault, including thoughts, feelings, behavior, and general health status;
- the behavior of sexual assailants, factors associated with assaultive behavior, and the effectiveness of deterrents upon potential assailants;
- strategies and programs to change basic attitudes about rape;
- analyses of social and health costs and benefits from early intervention and treatment following rape, compared with no action at all. (R-27)

In the area of *Services* we recommend that . . .

. . . the groups that accredit, certify, and license agencies and individuals who provide emergency/crisis, mental health, criminal justice, and other

human services should incorporate standards for the evaluation and treatment of sexual assault victims. (S-42)

... clear guidelines and protocols, such as exist in many rape crisis centers and hospital-based programs, should be sensitive to the experiences and needs of rape victims of both sexes and be developed by every community health facility. (S-43)

... institutions should provide a caring ombudsperson/expediter to assist each victim through the evaluation and treatment process. (S-44)

... programs serving rape victims should conform to national standards of various accrediting bodies in order to insure that they provide all the recommended elements of coordinated, effective victim services. (S-45)

... technical assistance — such as program design, clinical protocols, training curricula, and research results — should be readily available from a central clearinghouse (e.g., SHARE) to communities that want to develop their own service programs for victims of rape and sexual assault. (S-46)

... there be adequate public and private funding for programs serving victims of rape and sexual assault. (S-47)

RAPE AND SEXUAL ASSAULT: PREVENTION

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Laura X

Members of this work group introduced their recommendations with the following preamble:

- As part of their basic right to personal safety, all people — male and

female alike — have the right to control access to their bodies. Rape and sexual assault violate this basic right.

- Rape and sexual assault are brutal crimes with potentially life-shattering consequences for victims and with disruptive effects for society. The following recommendations are offered, therefore, to help society reduce and ultimately eliminate these crimes.

- "Sexual assault" is here defined as "nonconsensual sexual behavior, including stranger, acquaintance, and spousal assaults against either male or female victims."

- We recognize that substantial financial outlays will be required to carry out these recommendations. In view of the significance of rape and sexual assault as devastating public health problems, we urge that adequate funding for these recommendations be made available from both public and private sources.

In the area of *Education* we recommend that . . .

... increased public education should be carried out to bring about equality between women and men, since it has been shown that the rate of rape is low where the status of women is high. (E-30)

... public awareness should be heightened regarding 1) the legal, statistical, and human service definitions of rape and sexual assault; 2) the myths and facts surrounding each; 3) the impact of these crimes on victims and families; 4) the need for crisis services; and 5) the harm that comes to individuals and society from our nation's high tolerance of violence and aggressive behavior. (E-31)

... specific educational programs need to be designed for potential victims (especially high-risk populations), potential assailants (especially pre-adolescents and adolescents), and such professional persons as those in health care, law, religion, education, and human services. (E-32)

In the area of *Research* we recommend that . . .

... studies be carried out to determine which educational campaigns are most effective for preventing rape and sexual assault. (R-28)

... a clearinghouse on rape and sexual assault should be established to gather baseline data, provide technical assistance, and circulate information drawn from research, education, community action, and health and human services. (R-29)

... the human service, statistical, and legal communities and the general public need to re-examine their definitions of rape and sexual assault. (R-30)

- ... the way sexual aggression is portrayed in the mass media ought to be studied and evaluated for its effects upon the public health. (R-31)
- ... researchers should give additional attention to the following areas:
 - victim and bystander strategies that do or do not stop rapes in progress;
 - how the mass media do or do not encourage sexual assault;
 - treatments that do or do not change assailant behavior;
 - behavioral antecedents of assaultive behavior;
 - the role of incarceration in prevention;
 - situations and conditions in which rape occurs;
 - and the constraining effects of a person's fear of rape. (R-32)
- ... qualified researchers should be called together to set an agenda of the research that needs to be done in rape and sexual assault. (R-33)

In the area of *Services* we recommend that . . .

- ... all sexual offenders, especially adolescents and pre-adolescents showing sexually deviant behavior, should be identified, evaluated, and treated as early in life as possible. (S-48)
- ... the criminal justice system should clearly recognize sexual assault as a serious violent crime; that sanctions, including incarceration, should be imposed upon assailants commensurate with the devastating impact of the crime upon their victims; and that treatment to prevent future criminal behavior be part of sentencing wherever possible. (S-49)
- ... all remaining states and territories should remove the husband's exemption from prosecution for the rape of a wife, as is now the case in 28 states. (S-50)
- ... designers of cities, buildings, and transportation systems should pay more attention to the problem of reducing the risk of sexual assault in their projects. (S-51)

SPOUSE ABUSE: EVALUATION AND TREATMENT

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Members of this work group on spouse abuse introduced their recommendations with the following preamble:

- The phenomenon of "spouse abuse" includes physical, sexual, and psychological abuse and is found in all social, economic, ethnic, and racial groups.
- Spouse abuse is a crime perpetrated primarily against women, often causing them serious injury and premature death and affecting the psychological development of their children and of other family members.
- Spouse abuse is not a private matter; it has ramifications beyond the immediate family.
- Spouse abuse is rooted in a sexist social structure that produces profound inequities in roles and relationships and in the way resources and power are shared by men and women in families.
- All public policies that encourage or support spouse abuse and other forms of interpersonal violence are wrong; they should be reviewed and changed.
- Interventions that "blame the victim" and do not hold the abuser accountable are ineffective and inappropriate.

In the area of *Education* we recommend that . . .

- ... information on interpersonal violence, including spouse abuse, should

be a part of the basic education and training curriculum for all health professionals (physicians, psychologists, nurses, social workers, counselors, health educators, etc.), as well as for teachers, lawyers, police, and others who serve the public. (E-33)

... information on interpersonal violence, including spouse abuse, should be part of post-graduate and continuing education for health professionals and faculty. (E-34)

... certification, licensing, credentialing, and board examinations should include questions on interpersonal violence and spouse abuse so that health professionals and faculty have at least minimum knowledge of these phenomena. (E-35)

... the identification of victims and abusers and some knowledge of appropriate interventions and intervention strategies should be part of standards of practice and recommended standards of care for such various health disciplines as nursing, psychology, social work, health education, and medicine (pediatrics, psychiatry, family practice, obstetrics-gynecology, orthopedic surgery, and emergency medicine). (E-36)

... the Surgeon General should develop a public information and education campaign identifying spouse abuse as a major public health problem. (E-37)

... realistic standards need to be developed to help reduce the level of violence in all mass media, since — despite occasional and excellent examples of self-regulation — violence is still over-represented in the media. (E-38)

In the area of *Research* we recommend that ...

... federal agencies should identify and coordinate their spouse abuse research and make sure that the results are widely disseminated. (R-34)

... the resources available for research on the prevention, causality, treatment, and intervention of spouse abuse and family violence ought to be proportionate to the high priority of this problem, when compared with other public health problems. (R-35)

... a number of research opportunities in violence ought to be pursued, such as ...

- longitudinal studies of victim/survivors of spouse abuse;
- research among different vulnerable populations at high-risk for spouse abuse, such as racial and ethnic minorities and persons with low socioeconomic status;
- evaluation of models of intervention and prevention in spouse abuse and of models of the processes by which abusers stop abusing;

- the kinds of state and local policies that effectively reduce violence and protect victims;
- risk factors that may predict homicide in violent relationships;
- the relationship between an abuser's intake of alcohol and drugs and the frequency, severity, and lethality of the abuse of his spouse;
- how personal and environmental factors interact and escalate spouse abuse;
- the relationship between violence in mass media and spouse abuse;
- the way psychological assessment tools may be adapted to measure the psychological impact and other post-traumatic stress disorders upon the victims of spouse abuse;
- relationships between stress-related disorders and spouse abuse;
- the long-term effects upon health and social service providers who work in the area of spouse abuse;
- the characteristics and coping skills of women who have left violent relationships;
- characteristics of batterers in order to determine causation of male aggression against women;
- the long-term impact on children who witness spouse (parent) abuse. (R-36)

In the area of *Services* we recommend that ...

... the first priority for intervention in spouse abuse must be to provide shelters, safe homes, and other protective environments for victims and their children. (S-52)

... every community should have available a full range of fully funded and fully coordinated health, mental health, legal, and social services for victims, abusers, and their children. (S-53)

... spouse abuse services should include the kind of innovative and creative treatments that address the specific economic, social, and cultural needs of vulnerable populations. (S-54)

... intervention strategies must hold abusers accountable for their violent behavior. (S-55)

... protocols for spouse abuse identification and intervention should be developed and used by health care professionals in all settings, such as emergency rooms, trauma centers, primary care sites, mental health centers, psychiatric hospitals, and physicians' offices. (S-56)

... all existing and proposed typologies should be examined to eliminate victim-blaming. (Consistent with this recommendation, we oppose the proposed new DSM III-R psychiatric diagnosis 301.89, Masochistic Per-

sonality Disorder, which may be applied to victims of spouse abuse. This diagnosis is victim-blaming, pejorative, and sexist. It would be harmful and counterproductive to identification, intervention, and prevention strategies.) (S-57)

... the Surgeon General should vigorously pursue adequate federal funding for spouse abuse programs, particularly the funding to carry out the Family Violence Prevention and Services Act. (S-58)

... questions concerning possible spouse abuse should be included on prenatal history forms and be routinely asked during medical, nursing, and social work assessments of pregnant women. A physically or sexually abused pregnant woman should be identified as having a high-risk pregnancy and be eligible for high-risk prenatal care. (S-59)

SPOUSE ABUSE: PREVENTION

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The members of this work group agreed that the following issues and problems need to be addressed by the recommendations:

- The acceptance of violence as a means of responding to and resolving interpersonal and marital problems is widespread in our culture.
- Women have historically been the most likely target of family violence;

hence, health care professionals must take the lead in guaranteeing the physical integrity of women.

- Spouse abuse and woman battering each has an incremental/developmental sequence, which, if unchecked, will result in increased physical, psychological, and social morbidity of the victims.
- The link between child abuse and spouse abuse is well-documented; therefore, efforts to prevent spouse abuse and woman battering are also major factors in the prevention of child abuse.
- The major objectives of a prevention program in spouse abuse and woman battering are to identify the problem, to protect the victim, to stop the violence, to expand the options, and to empower women.

In the area of *Education* we recommend that ...

... programs to prevent domestic violence should be developed by federal, state, and local educational agencies and carried out in institutions at all levels. These prevention programs should focus on the following:

- the causes, dimensions, consequences of, and responsibility for interpersonal violence;
- the relationships between violence and power, control, gender stereotypes, and sex roles; and
- the nonviolent resolution of interpersonal conflict. (E-39)

... national leaders in health care, politics, business, labor, religion, culture, and the professions should declare their opposition to spouse abuse and woman battering and should develop and distribute appropriate educational materials to their constituents. (E-40)

... the Surgeon General should initiate a major media campaign designed to prevent spouse abuse and woman battering. The campaign should highlight the following points:

- spouse abuse and woman battering are against the law;
- the physical integrity of *all* family members is a basic health right;
- spouse abuse and woman battering have serious health consequences;
- battering is not limited to any group, gender, racial minority, geographic area, or social class;
- normative male behavior is itself a potential health hazard;
- shared decision-making and nonviolent conflict resolution are preferable to male dominance and the use of force; and
- services are available for abusive adults and their victims. (E-41)

... curriculum materials on spouse abuse and woman battering should be introduced into the education, training, and continuing education of

doctors, nurses, social workers, teachers, court personnel, employee assistance counselors, psychiatrists, police, clergy, and all other health, social service, and criminal justice professionals. (E-42)

In the area of *Research* we recommend that . . .

. . . the factors that aid in the prevention of spouse abuse should be identified. (R-37)

. . . research and demonstration projects should be designed for the prevention of spouse abuse and woman battering. (R-38)

. . . existing intervention and treatment programs should be evaluated. (R-39)

. . . the different dynamics and consequences of abuse for men and for women — and the service implications of these differences — should be identified. (R-40)

In the area of *Services* we recommend that . . .

. . . health and social service personnel should uniformly define spouse abuse as any assault or threat of assault by a social partner, regardless of gender or marital status and whether or not they are present or former cohabitants. (S-60)

. . . the empowerment of women should be supported by expanding their social and economic options before and after the identification of abuse and by addressing such vital issues and services as pay equity, the enforcement of child support orders, adequate and low-cost housing, child care, and job training. (S-61)

. . . model protocols for spouse abuse and woman battering should be used in health settings for the early identification of such abuse and for aiding victims. (S-62)

. . . spouse abuse protocols need to be developed for secondary treatment sites primarily concerned with alcohol and drug abuse, suicide prevention, rape and sexual assault, emergency psychiatric problems, child abuse, and the homeless. (S-63)

. . . federal, state, and local initiatives to prevent child abuse should be mandated to directly address spouse abuse and woman battering as well. (S-64)

. . . the Regional Centers established under the 1984 reauthorization of the National Center for Child Abuse and Neglect should have spouse abuse and woman battering added to their charters and the National Advisory Board on Child Abuse and Neglect should be appropriately renamed (e.g., the National Advisory Board on Family Violence) and its membership expanded to represent these linked concerns. (S-65)

. . . shelters should be supported and encouraged to meet the emergency needs of all victims, including protection, housing, and violence. (S-66)

. . . each governor should designate a state office or agency as the focal point for programs and policies related to domestic violence. (S-67)

. . . the criminal justice system must acknowledge rape and sexual assault as crimes, regardless of the past or present marital relationship between victim and perpetrator. (S-68)

. . . battered women need to be assured that the violence against them will stop, and that they will receive equal protection under the law and a swift resolution of their cases. (S-69)

. . . Congress should make sure that the full protection of the law in matters involving domestic violence is provided for all families living within exclusive federal jurisdictions. (S-70)

. . . new programs in education, treatment, and counseling need to be developed to help stop abusive men from committing further acts of violence. (S-71)

Plenary Session V

Response to the Recommendations

Presented by C. Everett Koop, MD
Surgeon General, USPHS
Tuesday afternoon, October 29, 1985

This Workshop may be a new departure, but the sheer number of victims — some 4 million — who cry out for help each year demands a public health response. If prevention is the business of public health, where better to focus attention than on this scourge of violence that permeates every level of our society — where victims live not only in fear and dread, but they also desperately try to sort out the shame and the guilt and the fear that competes with their feelings of love and loyalty to their families. While our attention has been directed primarily at interpersonal violence within the family, we seek to address the causes and effects of such violence outside the family as well.

Because this is the first Surgeon General's meeting on the subject of violence, the scope may be more diffuse than some would have wished. We have focused on public health, with additional participants representing the law, the criminal justice system, and social services. I would want the next workshop to focus more directly on the partnership of health and justice.

Your recommendations are just what I had hoped for. It should be possible for individual health professionals as well as the leaders of major

health institutions and associations to understand and act on them. Several themes do recur in the recommendations from among the 11 work groups: education of the public on the causes and effects of violence, education of health professionals as to better care for victims and better approaches to violence prevention, improved reporting and data-gathering, some additional research, and increased cooperation and coordination — "networking," if you will — among health and health-related professions and institutions.

Senate Hearing

I will begin carrying out that first recommendation of public education tomorrow when I lead off the witnesses at a special public hearing before Senator Paula Hawkins' Subcommittee on Children, Families, Drugs, and Alcoholism. I will also send your recommendations to the Secretary of Education and will indicate your willingness to work with his Department to get something accomplished in our public and private schools, colleges, and universities.

As for professional education, in addition to a report in *Public Health Reports*, I will post your recommendations on the Surgeon General's electronic bulletin board as soon as possible. The bulletin board, which is part of the American Medical Association's computerized Medical Information Network, or MINET, reaches about 26,000 physician subscribers.

I will also convey your concerns to many other professional groups, such as the American Nurses Association, National Board of Medical Examiners, Association of State and Territorial Health Officers, American Academy of Pediatrics, and the National Association of Social Workers.

As for the recommendations for research, I will convey them to the Assistant Secretary for Health and to the heads of the five PHS agencies who have the legal authority and the funds to conduct research. Several work groups have suggested new prospective, longitudinal studies of victims and families. Such studies are complicated and costly to mount. I honestly do not know how my colleagues will react to that, but I will certainly give them the suggestions.

I would also like to respond to some specific recommendations.

- You asked that the Surgeon General undertake an informational campaign about spouse abuse — something that I can and will do. I will transmit to the American College of Obstetricians and Gynecologists the recommendation for more sensitive evaluation and care for battered spouses who are pregnant. That also has my strong support.
- Both work groups on rape were concerned about the need for additional

research and recommended that a conference be held specifically to sort out what needs to be done. I endorse that suggestion and convey it to the Alcohol, Drug Abuse, and Mental Health Administration. You also called for greater interdisciplinary cooperation in the field of rape, and I agree that it is absolutely essential.

- In reference to assault and homicide, I understand your emphasis on paying special attention to the impact upon minorities. Rather than responding now, I would first like to see how the recommendations dovetail with those recently made by the Secretary's Task Force on Black and Minority Health.

- A number of recommendations concerning child abuse and child sexual abuse might well receive a more appropriate response from the Department's Office of Human Development Services, a co-sponsor of this Workshop. I intend to stay in close touch with that Office, as you clearly imply I should. I can say, however, that I agree completely with the recommendation that the abused child be treated promptly according to an evolving plan. The victim should not be seen merely as a pawn in some legal chess game.

Meanwhile, the PHS Division of Maternal and Child Health is beginning an aggressive public education campaign on child abuse and child sexual abuse and in May 1986 will co-sponsor a conference on child sexual abuse. The Division will also be disseminating materials related to these problems; I will ask them to include the recommendations in their mailings.

I'd like to add that I will carry the recommendations to certain other groups, such as the American Red Cross, the Boy Scouts and Girl Scouts, and the 4-H Clubs of America.

- From the day I was appointed in 1981, I've chosen the role of advocate for vulnerable, threatened older people in our society. I assure you that I will speak to this issue of elder abuse as well. I will deliver the recommendations on elder abuse to the Administration on Aging in the Department of Health and Human Services. The AoA interacts with about 1,200 centers on aging, so it is an important ally for getting broad exposure to the recommendations in this area. I will also discuss research in elder abuse with Dr. T. Franklin Williams, Director of the National Institute on Aging.

One work group recommended, in effect, that the Federal Government practice what it preaches, and I agree completely. Hence, I'm pleased that we've had a strong delegation from the Department of Defense at the workshop. They represent not only the policy function but also the

line function, the people who actually deliver health care to servicemen and women and their dependents.

What PHS Can Do

Let me share what the Public Health Service itself can do, is doing, or will do in respect to interpersonal violence. The National Health Service Corps, for example, is a PHS organization of health care professionals working in medically underserved areas, most of them remote rural areas or distressed inner-city neighborhoods. The Corps will be absorbing as many of the recommendations as possible into its continuing medical education program for the 3,100 NHSC officers in the field. And we have agreement from the Indian Health Service that the same actions would be useful for their personnel, too.

The 60,000 PHS employees are a cross-section of American society; they also have their share of personal problems, for which we have an employee counseling service. I understand that domestic violence will be receiving more attention from that counseling service during the coming year, including the establishment of a support group for battered women within PHS.

I believe the recommendations will be especially significant for the National Institute of Mental Health, which supports research in violence and anti-social behavior. I'm sure your thoughts regarding trends and emphases will be carefully studied by NIMH personnel and by the PHS people who work with migrant health centers, community health and mental health centers, state and local health agencies, and so on. I'd like them to have a heightened awareness of interpersonal violence in the conduct of the important grass-roots programs in public health.

Regional Follow-Up

Some of the participants are thinking ahead to follow-up activities to this Workshop. Regional meetings and some educational programs are being discussed. I hope that you will drop me a note about subsequent developments in this campaign against interpersonal violence. For my part, I pledge that my Office will put that information together for a 6-month follow-up report and a 12-month report. I agree with the strong recommendation of greater coordination and information-sharing within — and among — the health professions.

A final word. The causes of interpersonal violence, especially family

violence, are complex, multi-faceted, and extend into the social and cultural fabric of society. Sometimes the etiologic agent may be far removed from the narrower realm of health care. However, any remedies undertaken by a health official, including — and especially — the Surgeon General, must be consistent with his actual sphere of responsibility and influence and moral persuasion. Several recommendations — thoughtfully conceived and vigorously presented — are nevertheless well outside that public health sphere. But I want to assure you that, when and where feasible, I will transmit those recommendations as the sincere concerns of participants of this Workshop, even though they address social and political problems well beyond the influence of our colleagues in medicine, nursing, public health, psychology, and health-related social services and of the Surgeon General and the Public Health Service.

As long as I am Surgeon General, those who are victims of violence in this country will have a strong advocate in my Office.

Thank you.

The "Delphi Survey"

In the spring of 1985, in anticipation of "The Surgeon General's Workshop on Violence and Public Health" scheduled for late October, the Public Health Service decided to incorporate a Delphi survey in its pre-Workshop planning. The contractor was Survey Research Corporation.

Delphi surveys are designed to measure the collective wisdom of a group of experts. The participants are asked a series of questions, or exposed to the group averages, and are then invited to reconsider their positions. The process continues until a consensus emerges.

PHS felt that a Delphi survey preceding the Workshop would be of value on three counts.

1. It would give a sense of shared purpose to participants who had no prior contact with each other.
2. It would serve to clarify positions in advance of the Workshop, thereby shortening the time needed to explore viewpoints. The Workshop could, therefore, go directly into action the moment it convened.
3. It would help sustain interest in the Workshop during the inactive summer months.

Everyone on the invitation list was invited to participate in the Delphi and virtually all agreed: an unusually generous response.

Delphi I (the first iteration) was launched in June. It contained three broad questions representing the Workshop's areas of interest.

Q1 What is the role of education?

Q2 What should be done in research?

Q3 What should be done about the delivery of medical, health, and social services?

Under each question, there were statements that asked for agreement or disagreement on an 11-point scale. There was also space to propose additional statements for evaluation by the group.

The substance of statements proposed twice or more were included in Delphi II and III (the next iterations). Neither the Public Health Service nor Survey Research Corporation proposed or vetoed statements. Delphi II and III were, therefore, the products of the participants.

With Delphi III in late August, the concentrations were well established and there were no additional statements proposed. The Delphi survey was, therefore, over.

Results

Response to the survey statements is measured by an 11-point scale used as a continuous variable from "1" signifying total agreement to "11" signifying total disagreement. The midpoint "6" is the neutral position.

Two statistics are used to describe the results.

The first is the *mean*, or arithmetic average. It is interpreted as follows:

- 1-2 : very close to complete agreement
- 3-4 : substantial or general agreement
- 5-7 : verging toward or in the neutral area
- 8-9 : substantial or general disagreement
- 10-11: very close to complete disagreement

The second is *support level*. This is the total number (of percent) on one side or the other of the neutral position. The following is an example:

Scale Value		Number of Respondents	
1	AGREEMENT	5	
2		9	
3		36	
4		25	
5		5	Total above 6 is 80
6	NEUTRAL	5	
7	DISAGREEMENT	2	Total below 6 is 15
8		3	
9		3	
10		4	
11		3	
Total		100	

In the example, the positive (agreement) support level is 80, the negative (disagreement) support level is 15. The neutral position is 5. A positive support level of 80 is high, since a substantial majority shows some level of agreement with the position.

The *mean* and the *support level* taken together are usually an adequate

description of the results. In the few cases where they are not, the distribution of the data will be given in the text.

The following results of the survey are shown in question/statement order.

Q1 What is the Role of Education?

The set of 14 statements under this broad question focused mainly on action recommendations. In the few instances where theoretical positions were offered, such as "education can change the mores," there was a significant but relatively unenthusiastic response. On the other hand, positive support levels for training in recognition, reporting, and other situations calling for direct action were all extremely high.

Q1a POLICE SHOULD BE TRAINED IN EFFECTIVE METHODS OF INTERVENTION.

The mean is 1.8 and the positive support level is 99%: an extremely strong showing for this and the two related statements that follow.

Q1b HEALTH PROFESSIONALS SHOULD BE TRAINED TO RECOGNIZE DOMESTIC VIOLENCE.

The mean is 1.6 and the positive support level is 100%.

Q1c HEALTH PROFESSIONALS SHOULD BE TRAINED IN VIOLENCE-REPORTING PROCEDURES.

The mean is 1.8 and the positive support level is 99%.

Q1d HEALTH PROFESSIONALS SHOULD BE TRAINED IN VIOLENCE INTERVENTION PROCEDURES.

The mean is 2.9 and the positive support level is 95%: agreement with the position but with some reservations. We speculate that these may have to do with the practical consideration of danger to the intervening person.

Q1e INTRODUCE VIOLENCE PREVENTION IN FAMILY LIFE COURSES IN THE SCHOOLS.

The mean is 2.3 and the positive support level is 96%.

Q1f EDUCATION CAN CHANGE THE MORES (AND SOCIAL NORMS) THAT DICTATE VIOLENT BEHAVIOR.

The mean is 4.1 and the positive support level is 81%. But there is a substantial 38% cluster around the generally neutral 5-6-7 area.

Q1g EDUCATION CAN LEAD TO BETTER COMMUNICATION SKILLS AND THEREFORE LESS VIOLENT BEHAVIOR.

The mean is 4.0, with positive support at 83%: a slightly better showing than the preceding statement, but in the same area of general agreement.

Q1h IMPROVE PUBLIC AWARENESS OF LEGAL RIGHTS AND AVAILABLE SERVICES.

With a mean of 2.7 and a positive support level of 98%, agreement is unequivocal. The next statement, which proposes a method to achieve this, is even more acceptable.

Q1i USE THE MASS MEDIA IN A POSITIVE EDUCATION PROGRAM AGAINST VIOLENCE.

The mean is 2.0 and the positive support level is 96%.

Q1j TRAIN AND CERTIFY FORENSIC PSYCHIATRISTS AND PSYCHOLOGISTS.

The mean is 5.0 and the positive support level is 60%: a response that tends toward the neutral position. Response to the next, related statement is even more so. Several respondents wrote "why?" to both statements.

Q1k TRAIN AND CERTIFY FORENSIC SOCIAL WORKERS.

The mean is 5.3 and the positive support level is 52%.

Q1l HEALTH EDUCATION, COMBINED WITH POSITIVE MODELING AND SUPPORT FOR NON-VIOLENT RESPONSE, CAN LEAD TO LESS VIOLENT BEHAVIOR.

The mean is 3.9 and the positive support level is 85%: general but not enthusiastic agreement.

Q1m GIVE CHILDREN EXPLICIT EDUCATION IN NEGOTIATION TACTICS AND CONFLICT RESOLUTION.

The mean is 2.9 and the positive support level is 95%: a clear acceptance of the position.

Q1n PROVIDE PROFESSIONALS DEALING WITH VIOLENCE WITH SENSITIVITY TRAINING AND IN-DEPTH CASE CONSULTATION.

The mean is 3.5 and there is a positive support level of 83%; thus, there is general, but not total agreement.

Q2 What Should Be Done in Research?

The 16 statements under this question were a mix of specific projects and generalized approaches. In general, the group showed strong support for practical rather than theoretical projects and for the study of environmental rather than biological factors in violence. For example, statements that called for the development of intervention field models or for the evaluation of existing programs had mean values of 2.6 and 1.9, while those that dealt with verbal skills or the structure of genes had values of 5.0 and 7.7.

Q2a NEUROPSYCHOLOGICAL AND BIOMEDICAL AREAS HAVE BEEN NEGLECTED.

The response is neutral, with a mean of 5.8.

Q2b ANALYSIS OF STRUCTURAL (ENVIRONMENTAL) PROBLEMS IS THE KEY TO BETTER RESEARCH.

There is general support for the statement with a mean of 4.2.

Q2c RESEARCH SHOULD BE FOCUSED ON THE MORE VULNERABLE, HIGH-RISK POPULATION GROUPS.

The mean is 3.7 and the positive support level is 85%, which indicates a favorable position on the statement.

Q2d DETERMINE THE FUNCTION OF POOR VERBAL SKILLS IN RELATION TO VIOLENCE.

The mean is 5.0 and the positive support level is 58%, a marginally neutral response.

Q2e DETERMINE THE RELATIONSHIP BETWEEN VIOLENCE AND THE ABUSE OF DRUGS AND ALCOHOL.

The mean is 3.0 and the support level is 93%. Evidently there is considerable interest in exploring the drug-alcohol-violence hypothesis.

Q2f THOSE DOING RESEARCH ON VIOLENCE SEEM TO KNOW LITTLE ABOUT IT.

The mean is 6.3 and the negative support level is 31%. Most of the response—60%—is in the 5-6-7 neutral range. Clearly, the respondents were not able to express a clear judgment here.

Q2g PRIVACY LAWS HINDER RESEARCH ON VIOLENCE.

The mean is 5.6 and 52% are at the neutral (6) point. Some of the write-in comments indicate that the subject is a mystery to many of the participants.

Q2h MORE INTERDISCIPLINARY RESEARCH IS NEEDED.

With 95% positive support and a mean of 2.6, the response is unequivocal.

Q2i MORE RESEARCH ON INNATE CHARACTERISTICS, SUCH AS GENE STRUCTURE.

The position is generally rejected: a mean of 7.7 and a negative support level of 72%. (See also the related Q2a.)

Q2j CONCENTRATE ON APPLIED RATHER THAN PURE RESEARCH.

There is substantial agreement with the position at a mean of 4.1 and a positive support level of 67%.

Q2k DEVELOP FIELD MODELS OF EFFECTIVE INTERVENTION.

The positive support level is 97% and the mean is 2.6. There is no doubt that the group is strongly in favor of this kind of pragmatic research.

Q2l INVESTIGATE VIOLENCE AS NORMATIVE BEHAVIOR.

There is substantial agreement with a 3.8 mean and a support level of 84%.

Q2m INVESTIGATE THE RELATIONSHIP BETWEEN STRESS AND VIOLENCE.

92% agree, with a mean of 2.8.

Q2n INVESTIGATE THE ETIOLOGY OF COPING SKILLS.

There is substantial agreement with a mean of 3.6 and 84% support.

Q2o DETERMINE THE RELATIONSHIP BETWEEN ABUSE IN CHILDHOOD AND HIGH RISK IN ADULTHOOD.

Strong agreement at a mean of 2.8 and a support level of 93%. The importance of this research may be stronger than the statistics indicate, since some who disagreed did so on the grounds that the relationship had already been established.

Q2p EVALUATE EXISTING PREVENTION AND INTERVENTION PROGRAMS.

100% support and a mean of 1.9 for this pragmatic approach.

Q3 What Should Be Done About the Delivery of Medical, Health, and Social Services?

These 14 statements were extremely diverse, as they dealt with specific actions and procedures. All the proposals were given varying degrees of support, except for the location of shelters in or near hospitals, which was viewed neutrally. Real enthusiasm, however, was reserved for the expansion of shelter and crisis facilities, for bringing schools and the justice community into the violence prevention network, and for creating multidisciplinary teams at the local level.

Q3a CREATE A CENTRAL DATABANK FOR CHECKING AND SHARING HOSPITAL RECORDS.

There is substantial agreement at a mean of 4.3 and a support level of 78%.

Q3b DEVELOP MORE SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE, BOTH ADULTS AND CHILDREN.

There is strong agreement at a mean of 2.9 and a support level of 93%.

Q3c LOCATE SHELTERS FOR VICTIMS IN OR NEAR HOSPITALS.

The group is neutral at a mean of 5.5 and 58% in the 5-6-7 scale range.

Q3d IMPROVE MEDICAL-SOCIAL SERVICES COOPERATION BY DEFINING AREAS OF RESPONSIBILITY.

There is substantial agreement with the position at a 3.1 mean and a 93% support level.

Q3e IMPROVE THE QUALITY OF PERSONNEL ENGAGED IN EMERGENCY MEDICINE.

87% agree at a mean of 3.3.

Q3f DEFINE TYPES OF EMERGENCY ROOM PATIENTS WHO REQUIRE THE ASSISTANCE OF A SOCIAL WORKER.

The mean is 3.2 and the positive support level is 91%.

Q3g BRING SCHOOL HEALTH FACILITIES INTO THE VIOLENCE PREVENTION NETWORK.

Strong agreement at a mean of 2.2 and a 97% support level.

Q3h CREATE MULTIDISCIPLINARY TEAMS AT THE LOCAL LEVEL.

96% support the position at a mean of 2.5.

Q3i DEVELOP STANDARDS THAT DEFINE WHAT IS ABUSE OF OLD PEOPLE.

There is substantial agreement at a mean of 3.1 and a support level of 91%.

Q3j BRING THE JUSTICE COMMUNITY INTO THE VIOLENCE PREVENTION NETWORK.

100% agree, with a mean value of 2.0.

Q3k IMPROVE THE QUALITY AND AVAILABILITY OF SHORT-TERM CRISIS INTERVENTION FACILITIES.

99% agree. The mean is 2.0.

Q3l CREATE LOCAL COORDINATING BODIES TO PREVENT THE DUPLICATION OF SERVICES.

78% agree and the mean value is 3.7. Some write-in comment feared this would mean further regulation.

Q3m DEVELOP STANDARDS OF CARE FOR OFFENDERS.

With a mean value of 4.0 and a support level of 76%, agreement is unenthusiastic.

Q3n MAKE QUALITY DAY CARE AVAILABLE TO ALL.

74% agree and the mean value is 3.6.

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CHAPTER 18

The Effects of Media Violence on the Development of Antisocial Behavior

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CAUSES FOR CONCERN

Central to an understanding of the research on media violence and aggressive behavior and to the public concern that has surrounded the issue are two demographic trends from the second half of this century: (a) the very large increase in youth violence since the late 1940s and (b) the dramatic increase in the exposure of our youths to the mass visual media during the same period. The co-occurrence of these two trends has focused scientific, policy, and public attention on the relation between youth violence and violence in the mass media.

Of course, the co-occurrence of increases in violent behavior and increases in violence in the media might be suggestive of a relation between them, but, by itself, it would hardly qualify as evidence. Over the past four decades, however, a large body of scientific literature on the relation between media violence and violent behavior that overwhelmingly demonstrates that exposure to media violence does indeed relate to the development of violent behavior has emerged (Huesmann, 1982; Huesmann & Miller, 1994). The relations are not statistically large, but they are robust, replicable, and large enough to generate social concern (Rosenthal, 1986). The more interesting issues have now become the microscopic questions about the psychological processes that produce this relation. What are the processes? What do these processes suggest about the effects of the emerging new visual media, about who is most at risk for learning aggression from the media, and about media's role in specific forms of aggression? What do these processes suggest about how to mitigate the effects of media violence on the viewing audience?

In this chapter we review most of the empirical research relevant to understanding how violence on television, in film, in music videos, in video games, and on the news can engender violent behavior in the audience. First, though, we must set the stage by reviewing the demographic trends in violent behavior and youth exposure to media violence by summarizing the psychological theory that appears most relevant for understanding the development of individual differences in aggressive behavior, and by describing the roles that the observation of media violence might play in that development.

Increases in Violent Behavior

Crime prevention and protection from victimization have clearly become of paramount concern to the U.S. public during the last decade. According to the U.S. Department of Justice (1990), by 1990, 56% of the adult population of the United States personally feared becoming a victim of a violent crime. In late 1994, Congress passed a bill introduced by President Clinton with one of the largest increases in funding for anticrime measures in history. This most recent concern of the public and government with violent crime is the culmination of constantly growing anxiety paralleling the dramatic increase in violent crime that has occurred since the end of World War II (described in Part One of this volume). Though few other highly developed Western societies (except those beset by terrorism, drug wars, and revolutionary social upheaval, e.g., Columbia, Russia, South Africa) have violent crime rates similar to those in the United States, most such countries (excluding Japan) have also seen violent crime increases since World War II, particularly among youths (World Health Organization [WHO], 1965, 1982, 1993).

Corresponding Introduction of Mass Visual Media

The large increase in interpersonal violence in the past half-century has occurred at the same time as have the other dramatic changes in lifestyles produced by the great technological revolutions of the late 20th century. For child development, among the most notable has been the introduction of mass visual media into the everyday lives of children. When two highly salient events co-occur, it is common to hypothesize a causal relation between them; so it is not surprising that speculation about the role of media violence in stimulating violent behavior has been prevalent ever since motion pictures depicting violent acts first were distributed. With the advent in the early 1950s of television, the speculation advanced to the point of theorizing, and the first studies were initiated.

When television was introduced to the United States in the 1930s, few Americans could afford a television set and programming was limited. It was not until 1950 that television began to expand dramatically. Between 1950 and 1960, television ownership rose from less

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than 5% to more than 60% (Liebert, Sprafkin, & Davidson, 1982, p. 3). Since the 1950s, the television industry has grown tremendously and programming is now extremely pervasive in U.S. society. By 1992, 98.3% of U.S. households contained at least one television, and the average number of television sets in homes was 2.1 (U.S. Bureau of the Census, 1993, p. 561). It is estimated that children between the ages of 10 to 11 watch approximately 28 hours of television a week and teenagers watch about 23.5 hours a week (Comstock & Paik, 1991, p. 57). African Americans and Hispanics are reported to spend more time viewing television regardless of their social economic status (Tangney & Feshbach, 1988), and those persons of a low social economic status are often the heaviest viewers (Rubey & Csikszentmihalyi, 1990). Furthermore, the increase in single parent homes and dual-working parents during the past decade has changed the environment in which the U.S. child views television. More and more often, children view television without supervision.

What is the content of the programming to which our children and youths are exposed during those 28 plus hours of weekly television viewing? Huesmann and Eron (1986) reported that in the late 1970s, about 15% of all programs in the United States could be classified as very violent. Contrary to popular belief, the percentage is about the same in most other Western countries. The absolute frequency of media violence, however, is much lower in most of these countries because far fewer programming hours are presented each week (Huesmann & Eron, 1986). More recently, Gertner and Signorelli (1990) reported that there were five to six violent acts per hour on prime time television and 20 to 25 acts on Saturday morning children's programs. The most recent and most detailed surveys (Mediascope, 1996) show little change in these figures. For example, 57% of all programs are reported to contain violence and 33% of those violent programs were categorized as very violent, yielding an overall rate of 19% for very violent programs.

Recent Changes and Advances in Mass Visual Media

Not only has television become more widely distributed, but a number of other significant changes in mass visual media have occurred in the last two decades that have heightened concern over the potential role of the media to stimulate antisocial behavior.

During the 1970s and 1980s, cable television grew to become a part of U.S. life. With its advent, the viewing selection changed drastically. In 1980, the continental United States had 17.7 million subscribers to cable television. By 1992, that number had grown to 57.2 million. In 1992, of the 92 million households with television, 60.2% subscribed to cable television (U.S. Bureau of Census, 1993, p. 561). Cable television brought increased programming selection to U.S. households. In addition to regularly broadcast network programs, viewers could watch recycled old films and movie box office hits during all hours of the day and night. Many of these shows had greater violent content than the normal network dramas.

The spread of the videocassette recorder (VCR) has also increased the availability of violent films for viewing. Home VCR equipment boomed during the late 1980s, bringing box office entertainment into the home. In 1980, 1.1% of households with television had VCR equipment. By 1990, that number had increased to 72.5% of households with television (U.S. Bureau of Census, 1993, p. 561). It is predicted that ownership of video equipment will rise

to between 75% and 85% before leveling off (Dorr & Kunkel, 1990). These increases in the United States are paralleled by increases in other Western countries (Greenberg, Linsangan, & Soderman, 1987). Not only does VCR equipment provide a mechanism through which children can view the most violent films, it erodes the ability of society to control their exposure as well.

Another new form of entertainment that has raised concern among child advocates is the music video. Music videos entered the family home during the 1970s and became pervasive in 1981 with the introduction of MTV—an all-music video channel. Music videos are viewed primarily by 12- to 34-year-olds (Hansen & Hansen, 1990a). Viewing time has been reported at about 1 hour each weekday and about an hour and a half on Saturdays and Sundays (Hansen & Hansen, 1990a). Music videos have been frequently criticized for portraying violence, and according to a report by Huston et al. (1992), 50% of music videos contain at least one occurrence of violence. However, it remains to be studied whether the amount of graphically portrayed violence that most children observe in music videos compares with the amount they observe in dramatic films and television shows.

Advances in technology also brought an interactive form of visual entertainment—the video game—into widespread use by the end of the 1970s. By the end of the 1980s, the home video game was a regular part of almost every child's life (Provenzo, 1991). By 1985, annual industry sales were at \$100 million, and by 1990 they reached a high of \$4 billion. A CBS News report projected that 1992 sales would reach \$6 billion (Provenzo, 1991). As video games have proliferated, violent video games have become a regular part of U.S. life, particularly for boys. In a survey of 357 seventh- and eighth-grade middle-class Americans, about 67% of girls played video games at least 1 to 2 hours per week at home and about 20% played in arcades. However, 90% of boys played at home and 50% in arcades. For boys, approximately half of the preferred games were violent and only 2% were educational (Funk, 1993). In the United States, video game revenues total \$5.3 billion, about \$400 million more than is spent at the movies (Elmer-Dewitt, 1993).

These technological advances have increased concerns about the extent to which extensive presentations of violence in the visual mass media increase violence in society. Music videos couple violent acts with repetitive lyrics; cable television and video equipment allow for unlimited access to unrated violent films; video games provide graphic visual displays of violence created at the control of the player; and interactive television is on the verge of explosion into U.S. society. Given these technological advances, the potential for the mass media to influence behavior—for better or for worse—would seem to be greater than ever. But before we can explore the empirical links between violent media and violent behavior in detail, we need to review the current state of theorizing about violent behavior.

THEORIES OF VIOLENT AND AGGRESSIVE BEHAVIOR

There are two clear conclusions that one can draw from the research to date on the development of human aggressive behavior. First, severe aggressive behavior is most often the product of

multiple causes. Second, the best predictor of aggressive or violent behavior is previous aggressive or violent behavior.

Multiple Causes

The existing research suggests that childhood aggression is most often a product of a number of interacting factors: genetic, perinatal, physiological, familial, and learning. In fact, it seems most likely that severe antisocial aggressive behavior occurs only when there is a convergence of several of these factors. The evidence linking these factors to the development of aggressive behavior is covered in other chapters in this volume (Part Two) and is not reiterated here. What is important for the investigation of the role of media violence is that no one should expect the learning of aggression from exposure to media violence to explain more than a small percentage of the individual variation in aggressive behavior.

Continuity Over Time

Equally strong is the evidence that habitual aggressive behavior emerges in the early years and predicts later aggressive behavior. Individual differences in social behavior related to aggression (e.g., early temperament) are apparent before age 2 (Kagan, 1988). By age 6, a number of children have adopted aggressive patterns of behavior in their interactions with others (Parks & Slaby, 1983). From that point on, the extent of aggressive behavior in children tends to increase into adolescence. By age 8, children are characteristically more or less aggressive over a variety of situations, and aggression becomes a relatively stable characteristic of the individual youngster predicting adult aggression (Emswiler, Kellam, & Rubin, 1983; Farrington, 1982, 1990; Huesmann, Eron, Lefkowitz, & Walder, 1984; Loeber & Dishion, 1983; Magnusson, Duner, & Zetterblom, 1975; Moffitt, 1990; Olweus, 1979; Robins & Ratcliff, 1980; Spivack, 1983). The more aggressive child becomes the more aggressive adult.

The Learning of Aggression

Within this framework of multiple causes and early emergence, is there any one process that seems most important in accounting for individual differences in aggression? Yes, taken as a whole, the past 50 years of research on human aggression suggest that habitual aggressive behavior in young humans is to a great extent learned from the child's early interactions with the environment (Bandura, 1973; Berkowitz, 1974; Eron, Walder, & Lefkowitz, 1971; Huesmann et al., 1984). Although genetic and physiological factors clearly predispose some children more than others toward aggression, it is mostly children's early learning experiences that mold them into youths who behave more or less aggressively.

What are the key elements of the child's environment that mold the development of aggressive behavior? One must distinguish between instigators that may motivate or cue aggressive responses and affect behavior immediately and those components of the child's environment that mold the child's long-term responses to these stimuli and socialize the child. An environment full of deprivations, frustrations, and provocations is one in which aggression

is frequently stimulated, as the high level of aggression in our urban ghettos attests. However, the environmental elements that are most important theoretically in determining individual differences in habitual responses to deprivation, frustration, and provocation are the child's family, peers, and cultural surroundings, including the mass media. Predisposing differences in arousal level, impulsivity, and irritability may be moderated or exacerbated by the child's early learning experiences; but once habitual patterns of behavior are well learned, they become very hard to change.

Because of the malleability of behavior in young children and the relative intractability of aggressive and violent dispositions once they have been developed, it is important that theories concerning the development of habitual aggressive behavior focus on behavior in young children. What are the dimensions and parameters of the socialization processes that lead to individual differences in habitual aggressive behavior? Through what psychological processes does the influence of this early socialization process extend into adulthood? These are key issues for understanding of the long-term effects of exposure to media violence.

Cognitions as Mediators of Socialization

In recent years, a number of researchers have offered theories that implicate the child's cognitions in the learning and maintenance of aggressive habits. These models put the stress primarily on cognitive processes and the steps through which a child must proceed to react appropriately, competently, and nonaggressively to a social situation. Among the most influential of these have been the revised formulation of Bandura (1986), the neo-associationist perspective of Berkowitz (1984, 1988), and the information processing theories put forth by Huesmann (1982, 1988; Huesmann & Eron, 1984) and Dodge (1982; Crick & Dodge, 1994). All of these theorists recognize the importance of predisposing factors and emotional abnormalities in stimulating anger and impulsiveness, but they stress the role that learned cognitions can play in moderating these effects. The common theme among these dominant, current theories of aggression is that the processes through which media violence exerts its effect must involve the child's cognitions and that it is through such cognitions that early sustained exposure to media violence influences behavior throughout the life course.

DIFFERENT METHODOLOGICAL APPROACHES TO RESEARCH ON MEDIA VIOLENCE

Before proceeding to review the empirical evidence concerning the relation between media violence and aggression, a few methodological comments are required. Four distinctly different types of studies have been undertaken to test the relation between exposure to media violence and aggressive behavior by the viewer: true-experiments performed in well-controlled but artificial settings; quasi-experiments performed in poorly controlled real-life settings; one-shot observational studies in real-life settings; and longitudinal observational studies in real-life settings. One common fatal error that many critics of the field have made (e.g., Freedman, 1984; Howitt & Cumberbatch, 1975) is to ignore one or more of these approaches and focus attacks narrowly on

one or two approaches. Thus, Freedman (1984) completely ignores true-experiments, in which cause and effect are easily teased apart, and criticizes the field studies for not demonstrating a causal relation. Others have attacked the true-experiments for being "artificial" and ignore the real-life field studies. A second common error of critics has been to ignore age differences in aggregating results. The dominant cognitive theories all suggest that media violence should have an effect on children who are developing their habitual styles of social behavior, but these theories make many fewer clear-cut predictions about the effects of media violence on adults. The lack of a relation among a sample of adults or even teenagers should not be taken as evidence falsifying a theory about children, yet it often has.

THE EMPIRICAL RELATION BETWEEN DIFFERENT TYPES OF MEDIA VIOLENCE AND AGGRESSIVE BEHAVIOR

Dramatic Violence

The majority of research on the relation between exposure to violence in the media and violent behavior has focused on the effects of watching dramatic violence on television and film. Experimental studies, static observational studies, longitudinal studies, and meta-analyses all indicate that exposure to dramatic violence on television and in the movies is related to violent behavior (Huesmann & Miller, 1994).

In contrived experimental studies, children exposed to violent behavior on film or television behave more aggressively immediately afterward. Large numbers of laboratory and field experiments have demonstrated this fact over the past quarter-century (see reviews by Comstock, 1980; Geen, 1983, 1990; Geen & Thomas, 1986). The typical paradigm is that randomly selected children who are shown either a violent or a nonviolent short film are observed as they play with each other or with objects such as *Bobo* dolls (Bandura, Ross, & Ross, 1961, 1963a, 1963b). The consistent finding is that children who see the violent film clip behave more aggressively immediately afterward. Just as children learn cognitive and social skills from watching people act out these skills, they learn violent behaviors from watching other people behave violently. Such results have been obtained both for aggression directed at inanimate objects (e.g., *Bobo* dolls) and for aggression directed at peers (Bjorkqvist, 1985; Josephson, 1987). In one very typical study Bjorkqvist (1985) in Finland exposed 5- to 6-year-old children to either violent or nonviolent films. These children were then observed playing together in a room by two observers who did not know which type of film each child had seen. Children who had just seen the violent film ended up being rated higher on physical aggression (hitting other children, wrestling, etc.), verbal aggression (screaming at others, threatening others), and aggression at objects (intentional destruction of toys, etc.).

The effects of violent television or films on the affective responses that mediate aggression have also been clearly demonstrated with valid experiments. For example, Bushman and Gorn (1990) demonstrated that violent videotapes elicit both aggressive cognitions and higher systolic blood pressure in college students.

It is also true that in the laboratory, children can be taught to be less aggressive by being shown films with prosocial models (Eron & Huesmann, 1986; Pitkanen-Pulkkinen, 1979). These short-term effects are not limited to children but have been observed in teenagers and adults, particularly when the dependent measures reflect attitudes or opinions rather than behaviors (Malamuth & Donnerstein, 1982). In these well-controlled laboratory studies, there can be no doubt that it is the children's observation of the scenes of violence that causes the changes in behavior. Some critics would dismiss these studies completely as "artificial" approximations of life (Freedman, 1984) and focus only on field studies. But such a position is not defensible in light of the complementary nature of experimental and nonexperimental research in this area (Huesmann, Eron, Berkowitz, & Chaffee, 1991).

The demonstration of a relation between the observation of dramatic television and film violence and the commission of aggressive behavior has not been limited to the laboratory. Evidence from field studies over the past 20 years has led most reviewers to conclude that a child's current aggressiveness and the amount of television and film violence the child is regularly watching are positively related to some degree. Children who watch more violence on television and in the movies behave more violently and express beliefs more accepting of aggressive behavior (see reviews by Anderson, 1977; Chaffee, 1972; Comstock, 1980; Eysenck & N 1978; Hcarold, 1979; Huesmann, 1982; Huesmann & Miller, 1994; Paik & Comstock, 1994; Wood, Wong, & Chachere, 1991). Clearly, this relation is robust though the effect size is not large by standards used in the measurement of intellectual abilities and varies as a function of environmental, familial, cognitive, and television programming variables. However, the relation is usually statistically significant and is substantial by the standards of personality measurements with children. Correlations of the magnitude usually obtained in the field can have real social significance (Rosenthal, 1986). Moreover, the relation is highly replicable even across researchers who disagree about the reasons (e.g., Huesmann, Lagerspetz, & Eron, 1984; Milavsky, Kessler, Stipp, & Rubens, 1982) and across countries (Huesmann & Eron, 1986). In contrast to the childhood data, significant correlations between adults' aggression and adults' concurrent violence viewing have been observed only rarely in the field.

Whereas these one-shot field studies showing a correlation between media violence viewing and aggression suggest that the causal conclusions of the experimental studies may well generalize to the real world, longitudinal studies can test the plausibility of causal hypotheses more directly. The data available from the few existing longitudinal studies do, in fact, provide additional support for the hypothesis that television violence viewing leads to the development of aggressive behavior. These longitudinal studies have employed a wide range of samples and methodologies, but all of the studies done with children seem to reveal long-term effects of exposure to television violence.

In a study initiated in 1960 on 870 youth in Columbia County, New York, Eron and his colleagues found that a boy's early childhood aggression in elementary school was statistically related to his aggressive and antisocial behavior 10 years later (after graduating from high school), even controlling for initial aggressiveness, social class, education, and other relevant variables (Eron,

Huesmann, Lefkowitz, & Walder, 1972; Lefkowitz, Eron, Walder, & Huesmann, 1977). A 22-year follow-up of these same subjects revealed that their early violence viewing also related to their adult criminality at age 30 (Huesmann, 1986).

A 3-year longitudinal study of children in five countries conducted by Huesmann and his colleagues in the late 1970s (Huesmann & Eron, 1986; Huesmann, Lagerspetz, & Eron, 1984) revealed that the television habits of children as young as first-graders also predicted subsequent childhood aggression. This was true for both boys and girls even in countries without large amounts of violent programming, such as Israel, Finland, and Poland (Huesmann & Eron, 1986). In most countries, the more aggressive children also watched more television, preferred more violent programs, identified more with aggressive characters, and perceived television violence as more like real life than did the less aggressive children. The combination of extensive exposure to violence coupled with identification with aggressive characters was a particularly potent predictor of subsequent aggression for many children. A field experiment conducted as part of this study also provided evidence that what is being learned from the observation of violence may be attitudes about aggression as much as specific behaviors. In this field experiment, aggression in a randomly selected experimental group of third-graders was reduced relative to a control group by changing their attitudes about the acceptability of the violence shown on television (Huesmann, Eron, Klein, Brice, & Fischer, 1983).

A few longitudinal studies seemed to produce results at variance with the thesis that media violence causes aggression, but closer inspection of most of these studies reveals that their results are not discrepant, but simply not strongly supportive of the thesis. (For a review, see Huesmann & Miller, 1994.) For example, NBC's longitudinal study conducted in the 1970s (Milavsky et al., 1982) actually reports regression coefficients that, although not significant, are in the predicted direction in 22 of 30 critical tests for the causal theory.

More recently, Centerwall (1989, 1992) has used aggregated population crime and media viewing data to argue that media violence is one of the major causes of increased crime rates in Western society. Using time series analyses of data from the United States, Canada, and South Africa, where television has been introduced only recently, he concludes that the introduction of television, with its associated frequent portrayal of violent acts, significantly increases interpersonal violence in a society. As discussed later in the section on news coverage, however, such conclusions must be treated judiciously because of the many threats to the validity of conclusions from quasi-experiments using aggregated population data.

Finally, one cannot complete a review of major studies on this topic without mentioning two meta-analyses that summarize findings from studies conducted over the past 30 years on media violence and aggression. Paik and Comstock (1994) calculated the obtained effect sizes for over 1,000 comparisons derived from 217 different experiments, static field studies, and longitudinal studies. After extensive analyses, they concluded that the association between exposure to television violence and antisocial and aggressive behavior is extremely robust. Furthermore, they conclude, "The data of the past decade and a half strengthens rather than

weakens the case that television violence increases aggressive and antisocial behavior" (p. 54). Wood et al. (1991) analyzed 30 comparisons in 23 studies in which the outcome variable was aggression measured in unstructured social interaction, such as a nursery school playground. They concluded that exposure to media violence significantly enhanced viewers' aggressive behavior when the findings were aggregated across studies, though the effect was not uniform across investigations.

Music Videos

The increasing popularity of several new forms of media that contain high levels of violence, such as music videos and video games, adds a new dimension to this relation between exposure to media violence and violent behavior. Content analyses of music videos have documented very high levels of violence (Baxter, Di Riemer, Landini, Laslie, & Singletary, 1985; Brown & Campbell, 1986; Caplan, 1985; Hansen & Hansen, 1989; Sherman & Dominick, 1986) and show that videos often portray antisocial behavior in a positive light (Hansen & Hansen, 1989). Although very few experimental or static observational studies have been conducted on the behavioral effects of watching violent music videos, several studies have been done on the effects they have on viewers' attitudes, finding that watching violent music videos increases viewers' acceptance and endorsement of violent behavior and attitudes (Greeson & Williams, 1986; Hansen & Hansen, 1989, 1990a). For example, Hansen and Hansen (1990a) found that after neutral music videos, subjects' evaluations of a target were more negative when the target made an obscene gesture toward the experimenter than when he did not. However, after viewing videos containing antisocial behavior, the obscene gesture did not decrease the subjects' rating of the target. Whereas these types of studies do not directly test the link between viewing and behavior, they do seem to indicate that exposure to antisocial rock music videos alters the viewers' judgments of antisocial behavior.

One genre that has garnered particular attention is that of rap music videos. As with music videos in general, little research has been done on the effects of rap music on aggressive behavior. However, two recent studies have looked at the effects of exposure to rap music videos on the attitudes of African American adolescents. One study found that exposure to nonviolent rap music videos that depict women in sexually subordinate roles increased females' acceptance of teen dating violence but had no effect on males' acceptance (Johnson, Adams, Ashburn, & Reed, 1995). A second study found that subjects exposed to violent rap music videos reported greater acceptance of the use of violence and increased probability that they would engage in violent behavior. In addition, when compared to those subjects who did not see rap music videos, in a hypothetical situation given to them after viewing the video, subjects exposed to either violent or nonviolent videos expressed a greater desire to be like the materialistic young man who uses illegal means to get what he wants than the young man in college who is aspiring to be a lawyer (Johnson, Jackson, & Gatto, 1994). These results indicate that rap music videos may, in fact, affect both male and female adolescents' attitudes toward aggressive behavior.

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Video Games

Video games also have become a focus of concern due to the high levels of violence they contain and the fact that children are active participants in the violence, rather than passive observers, as they are with television. As with music videos, video games are a fairly recent medium and as such their impact on the aggressive behavior of the players has not yet been studied extensively. However, the results of the studies that have been conducted, most of which are experimental studies done in the laboratory, seem to support the notion that observing and engaging with a medium that has violent content is related to violent behavior in the observer/player. Several studies have shown that children's aggressive play increases after playing a violent video game (Cooper & Mackie, 1986; Schute, Malouff, & Post-Gordon, 1988; Silver & Williamson, 1987). For example, one study looked at the differences in 28 four- to six-year-old children's play before and after viewing a violent cartoon and after playing a violent video game (Silver & Williamson, 1987). They found that children exhibited double the aggressive behavior and less prosocial behavior after playing the video game or watching the cartoon than at the baseline.

News Violence

Little research has been conducted specifically on the effects of watching violence in news coverage on behavior. From a theoretical perspective, however, there is little reason to believe that the effects on the audience of news violence should be much different from the effects of dramatic violence. True, the audience knows that the news violence is real, which might heighten its effects, but children, who are most likely to be affected by video violence, often also perceive dramatic violence (not to mention "reenactment" dramas) as "telling about life just like it is" (Huesmann & Eron, 1986). Furthermore, graphic portrayals of actual acts of violence are seldom shown in the news; rather, the story usually is reported after the fact.

Most of the investigations that have examined the effects of violent news on the audience have been time-series field studies that used aggregated population data to relate population trends to specific news events. They have yielded mixed results. On the whole, these studies support the theory of imitative suicide but provide only weak evidence for the occurrence of imitative violent crime after well-publicized violent events (Phillips, 1979, 1982; Simon, 1979; Stack, 1989). One study using monthly data from 1968 to 1980 found that publicized mass murders or suicides correlated with subsequent suicide rates, but not with subsequent homicide rates (Stack, 1989). Phillips's (1983) frequently cited finding of increases in violent crimes following televised prize fights has not been widely accepted by researchers because of methodological challenges raised by others (Baron & Reiss, 1985; see Phillips & Bollen, 1985, for a response). However, another study by Berkowitz and Macaulay (1971) reported that there was an increase in violent crimes, but not property crimes, after several high-profile murder cases in the early and mid-1960s, including the assassination of President Kennedy. The threats to the validity of the conclusions of all such time-series studies using aggregated population data are numerous. Thus, the relation between news

coverage of violent crime and violent behavior must still be considered unclear and needs to be investigated more rigorously in the future with prospective studies examining the longitudinal effects on individuals. Such research seems particularly vital as the nature of news coverage changes and the distinction between news and entertainment blurs with the increase in reality-based police shows that overrepresent the prevalence of violent crime (Olliver, 1994).

WHY IS EXPOSURE TO VIOLENCE RELATED TO VIOLENT BEHAVIOR?

The previous review, although brief, revealed a preponderance of evidence indicating that exposure to dramatic media violence is predictive of increased aggressive behavior in young children. The evidence that video games and music videos have the same effect is much weaker, but it is hard to understand how television and films could have an effect and video games and music videos would not have an effect. Let us now turn to the question of what processes produce these relations. In line with our previous discussion of the current state of theorizing about aggression, we need to focus on mechanisms through which media violence directly stimulates aggressive behavior, influences the cognitions controlling aggressive behavior, and influences the emotional and arousal processes underlying aggressive behavior.

Before exploring these processes, however, let us dispense with one old theory that has plagued discussions of the role of media violence for decades, the catharsis theory developed by Freud (1933). This theory posits that watching aggression on television acts as a purging of aggressive tendencies or drive. Certainly, physically aggressive actions can reduce tension in subjects who have been frustrated (Hokanson & Burgess, 1962), but so can physical exertion that is nonaggressive. The more important fact is that there are no convincing data to indicate that watching violent acts reduces tension or the propensity of one to act aggressively (Doob & Wood, 1972). The one field study often cited as demonstrating a catharsis process (Feshbach & Singer, 1971) has methodological flaws (Huesmann et al., 1991) that the authors have recognized. As shown earlier, the majority of evidence demonstrates that violence viewing and aggression are *positively* related, which contradicts the catharsis hypothesis. Furthermore, studies that have examined the relation between fantasizing about aggression and aggressive behavior have shown that children who fantasize more behave more aggressively (Huesmann & Eron, 1986; Viemer & Paajanen, 1992). As an explanation of the relation between aggressive behavior and viewing violence, catharsis theory can be put to rest.

Observational Learning of Behaviors

On the basis of the accumulated evidence, it seems clear that children learn both specific aggressive behaviors and cognitions supporting more complex aggressive behaviors through observational learning. It has become an accepted tenet of developmental theory that through observational learning and vicarious reinforcements (Bandura, 1977, 1986), children develop habitual modes of behavior that are resistant to extinction. The application of observational learning to explain the acquisition of specific aggressive behaviors

that children observe in others (in person or in the media) is straightforward (Bandura, Ross, & Ross, 1963a). But there are additional predictions of vicarious learning theories that also have been confirmed. For instance, it has been shown that the extent to which a child imitates an actor is greatly influenced by the reinforcements received by the actor. If the actor is seen being rewarded for aggressive behavior, the child is more likely to imitate that behavior (Bandura, 1965; Bandura et al., 1963a, 1963b; Walters, Leat, & Mezei, 1963). If the actor is punished for a behavior, that behavior is less likely to be modeled (Bandura, 1965; Walters & Parks, 1964). Other studies have indicated that the persistence of such learned behavior seems to depend on the direct reinforcements that the child receives (Bandura, 1965; Hayes, Rinoover, & Volosin, 1980). Finally, whether the child identifies with the model (Huesmann & Eron, 1986; Huesmann, Lagerspetz, & Eron, 1984) and whether the model is perceived as possessing valued characteristics also appear to influence whether a child will imitate the model (Bandura, 1977; Hicks, 1965; Neely, Heckel, & Leichman, 1973; Nicholas, McCarter, & Heckel, 1971).

Observational Learning of Cognitions

In more recent years, a number of other theorists, drawing both on Bandura's social learning theory and cognitive psychology, have extended the concept of observational learning to argue that children also learn cognitions supporting aggressive behavior that generalize across time and situations (Huesmann, 1982, 1988; Huesmann & Eron, 1984; Huesmann & Miller, 1994). Huesmann has argued that children learn, from observing violent dramas in the media, scripts for complex aggressive behaviors, normative beliefs, attributional biases, and attitudes supporting aggression. *Scripts* are programs for behaviors and *normative beliefs* are internal self-regulating standards that filter out unacceptable behaviors (Huesmann & Guerra, 1997). Huesmann argues that both scripts and normative beliefs are learned through a process in which observational learning interacts with cognitive rehearsal of the observed material and instrumental enactive learning. The observed correlations between violence viewing, aggressive fantasizing, and aggression reflect the role of fantasizing as rehearsal (Huesmann & Eron, 1986; Vlemore & Paajanen, 1992). According to this theory, a child's observation of dramatic or real violence in childhood contributes to the construction of lasting cognitive structures that affect the child's aggressive attitudes and behavior into adulthood. These cognitive structures contribute to the perpetuation of aggressive behavior even in the face of negative consequences by providing false evaluation of the outcome of the behavior, limiting the ability to generate any alternative scripts, causing an alteration of evaluative schema to make aggression more palatable, and arranging the environment so aggression is more acceptable (Huesmann, 1988).

A substantial body of data has accumulated indicating that media violence does, in fact, change beliefs and attitudes about violence. The more televised violence a child watches, the more accepting is the child's attitude toward aggressive behavior (Dominick & Greenberg, 1972). Equally important, the more a person watches television, the more suspicious a person is, and the greater is the person's expectancy of being involved in real violence (Gerbner & Gross, 1974, 1980). Why is this? From an infor-

mation processing standpoint, attitudes are attributions, rules, and explanations induced from observations of behavior. They serve as heuristics for future behavior. If a child's, or even an adult's, major exposure to social interaction occurs through television, the conception of social reality would quite naturally be based on such observations. Heavy television viewers would have more positive attitudes toward aggression because they perceive aggressive behavior to be the norm. Perhaps even the perception of what is an aggressive act changes.

Cognitive Justification Processes

The justification hypothesis posits that people who are aggressive like to watch violent television because they can then justify their own behavior as being normal (Huesmann, 1982). It involves the observational learning of attitudes, but it operates in the opposite direction from the process described earlier. According to this theory, television violence viewing does not stimulate the child's aggressiveness; it results from it. A child's own aggressive behaviors normally should elicit guilt in the child, but this guilt could be relieved if the child who has behaved aggressively watches violent television, which justifies his or her own aggressiveness.

Unfortunately, little research has been conducted to test this model. A number of psychologists have suggested that aggressiveness might be a precursor of violence viewing (e.g., Kaplan & Singer, 1976), but most of them have operated in a theoretical vacuum without any process model to explain such an effect. Unfortunately, the one experiment aimed at assaying whether aggressive behavior might be a precursor of violence viewing demonstrated only that subjects who are told to think about aggressive words choose to watch aggressive films afterward (Fenigstein, 1979). More research clearly needs to be conducted to test this theory.

Cognitive Cueing/Priming

Whereas the observational learning process explains how exposure to media violence can teach lasting aggressive habits, priming theory can account for how aggressive habits learned in other venues may be triggered by violent media displays. Berkowitz (1984) has proposed that "the aggressive idea suggested by a violent movie can 'prime' other semantically related thoughts, heightening the chances that viewers will have other aggressive ideas in this period" (p. 411). In this way, viewing an aggressive act on television activates thoughts, emotions, and even behaviors that are cognitively associated with the act. This idea of cognitive priming is useful in explaining why the observation of aggression in the media is often followed by aggressive acts that differ from the observed behavior. Many studies have demonstrated this phenomenon using television violence (Berkowitz, 1970; Berkowitz & Rogers, 1986; Worchel, 1972; Wyr & Hartwick, 1980; Wyr & Strull, 1981) and violence in music videos (Hanson & Hansen, 1990a). For example, in one study it was found that subjects who viewed slides of weapons were more willing to severely punish a target than were the subjects who viewed neutral slides (Leyens & Parks, 1975). Presumably, viewing the weapons stimulated other aggressive ideas and emotions that then affected the viewers' subsequent attitudes and behaviors.

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A related view focuses on the importance of cues in the retrieval process of aggression learned through observation. The idea of cueing is that at the time of observation the viewer encodes both the aggressiveness of the act and any relevant pieces of information in the surrounding environment (such as a particular object) that later can serve as retrieval cues. One study that demonstrated this effect was Josephson's (1987) study of schoolboy hockey players. Josephson deliberately frustrated the boys who were then shown either a violent or nonviolent television program. A walkie-talkie was used by the aggressive actor in the program and thus was predicted to act as a retrieval cue. In fact, this seemed to be the case because during a subsequent hockey game, boys were most aggressive if they had previously seen the aggressive film and the referee carried a walkie-talkie. This idea of cueing seems particularly important in reference to the effects of music videos because the audio portion of the video may serve as a cue for the aggression observed in the video, causing these aggressive acts to be retrieved when the music is heard in the future.

Emotional and Cognitive Desensitization

Cognitive desensitization refers to the idea that the more an individual is exposed to violence, the more violence will come to be seen as a normal and acceptable form of behavior. This process, in turn, will increase the person's acceptance of violent behavior, decrease the individual's emotional reaction to violence, and make it more likely that the individual will model the aggressive acts. Many studies have demonstrated this effect in both children (Drabman & Thomas, 1974; Thomas & Drabman, 1975) and adults (Linz, Donnerstein, & Penrod, 1988; Malamuth & Check, 1981).

One designates the changes in attitudes brought about by frequent violence viewing as a cognitive desensitization to violence. Similarly, there is some evidence that a real physiological desensitization can occur. In a quasi-experimental field study (Cline, Croft, & Courier, 1973), boys who regularly watched a heavy diet of television displayed less physiological arousal in response to new scenes of violence than did control subjects. Although these results have apparently been difficult to replicate in the field, Thomas, Horton, Lippincott, and Drabman (1977) discovered similar short-term effects in laboratory studies of changes in skin conductance in response to violence. It should not be surprising that emotional and physiological responses to scenes of violence habituate as do responses to other stimuli. It is more difficult to make the case that such habituation would influence the future probability of aggressive behavior. One needs to argue that the arousal that is naturally stimulated by viewing violent behavior is unpleasant and therefore is a negative reinforcer of one's own violent behavior. Several studies do seem to support this hypothesis (Halpern, 1975; Winn, 1977).

Arousal and Excitation Transfer

On the other hand, some theorists have argued that arousal heightens the propensity of the person to behave aggressively, and television violence increases or perpetuates arousal. Studies by Green and O'Neal (1969) and Zillmann (1971) demonstrate that increasing a

subject's general arousal increases the probability of aggressive behavior. In the typical study, a subject engages in physical activity that raises his or her heart rate and then is tested on the tendency to respond aggressively in response to provocation (Zillmann, Katchor, & Milavsky, 1972). Although there is some tendency of subjects to respond more "aggressively," for example, select stronger punishments for someone else, in this situation it is difficult to separate the arousal from the physical exertion as the cause.

This excitation transfer theory has also been used to explain how nonviolent pornography could stimulate aggressive behavior. Zillmann (1978, 1983, 1984) posited that physiological arousal produced by a sexual or other stimulus in one situation may influence aggressive behavior in another situation that is close in time. It is argued that when excitation is produced by more than one source of stimulation, the individual is unable to distinguish between the excitation produced by each source. Excitation from multiple sources is thought to be additive, so that the arousing sexual stimulus can have the effect of intensifying anger, for example. Presumably, people at higher levels of arousal are more likely to respond strongly and impulsively to provoking stimuli and therefore are more likely to behave aggressively due to this "transferred" excitation. The duration of such excitation is relatively short term (i.e., undetectable after a few hours); thus, this theory cannot be invoked to explain long-term effects of media violence.

This process of excitation transfer could also explain how the viewing of violent music videos could increase aggression. Although this idea is plausible, the results with music videos have been mixed. One study did find that the level of arousal caused by the music was strongly related to the subjects' rating of the appeal of the music video and to the strength of the emotions generated by the video (Hanson & Hanson, 1990b). These emotions were mostly positive, however, which might not affect aggressive behaviors. Nevertheless, these findings could have profound implications as music videos and video games (which have three sources of stimulation: visual, audio, and kinetic) become more prominent forms of entertainment. However, more research needs to be done to confirm an excitation effect on aggressive behavior.

WHO IS MOST AT RISK?

Whereas the research reviewed in this article provides support for the hypothesis that viewing television violence leads to the development of aggressive behavior, clearly it is not the only cause of aggressive behavior. Many other factors, both individual and societal, also contribute to its development. Of particular interest are those factors that put an individual most at risk. Research on this topic is quite scarce; however, there has been some theorizing and a small amount of empirical data that have tried to identify the societal- and individual-level factors that put some people more at risk for being affected by viewing violence in the media.

Societal-Level Risks

Much has been written about the "culture" of violence that has developed over the years in the United States (Anderson, 1990). It has been speculated that living in a culture that rewards violence

puts a child at a higher risk for being affected by the violence viewed on television, and some studies have shown this to be true. For example, our cross-national study found that kibbutz-raised children in Israel were significantly less affected by viewing television violence than were city-raised Israeli children and children in Poland, Finland, and the United States (Huesmann & Bachrach, 1988). This result may be due to the powerful group norms against aggression prevalent in the kibbutz society. Thus, television has a greater effect on the development of aggression when the aggressive behaviors learned by observing television are not countered by a norm against aggression. Similarly, the same cross-national study found that the longitudinal effects for boys are very similar in the United States and Finland, but the results for girls were not. In Finland, girls do not seem to be affected by the amount of violence they view on television (Huesmann, Lagerspetz, & Eron, 1984). This result was explained in terms of differing cultural norms in the two countries. Finnish girls may be more encouraged than Finnish boys to inhibit whatever aggressive behaviors are stimulated by television violence, whereas girls in the United States in the 1980s and 1990s are being encouraged to behave as aggressively as boys. The power of cultural norms to influence aggression has been documented in a number of other countries and cultures as well (Landau, 1984).

It also appears as if the family environment can increase or decrease an individual's propensity to be affected by viewing violence. Tangney and Feshbach (1988) found that certain family television behaviors were correlated with lower levels of aggressiveness and restlessness. These family characteristics include (a) establishment of television rules, (b) parents who engage in active discussions with children, (c) regulation/mediation of television use, and (d) lower frequency of television viewing.

Putting together these findings concerning society and family with our earlier discussion of the importance of attitudes, beliefs, attributional biases, and cognitive scripts in controlling social behavior, one can readily see how children in neighborhoods and countries beset by violence could be most at risk for being influenced by media violence. The more realistic and appropriate the depicted violent behaviors may seem, the more likely they are to have a lasting influence. The more violence and retribution are sanctioned by the family and the culture, the less possibility there is for societal and family forces to counteract the pernicious influence of media violence.

Individual-Level Risks

In addition to varying societal-level factors, some risk factors for susceptibility to media violence lie at the individual level. Many factors have been suggested as risk factors, such as neurological deficits, age, cognitive ability, ethnicity, social class, sex, personality characteristics, and mental health differences, but little empirical work has been done to test these hypotheses; and the studies that have been conducted have provided mixed results (Dorr & Kovacic, 1980).

Many of the theories used to explain why exposure to violence in the media is related to aggressive behavior posit that young children are at a higher risk for being affected by what they view on television due to their impressionability and less mature cognitive struc-

tures. However, research on age difference appears to be mixed, indicating that whereas younger children may be more susceptible to influence from television, no age is immune from influence (Dorr & Kovacic, 1980). A related factor is the differences in cognitive ability between children of the same age. It is theorized that children with greater cognitive ability are less susceptible to the effects of viewing violence on television because they realize that the images on television do not represent reality, and, in fact, children who perceive television violence as less realistic do tend to be less aggressive (Huesmann & Eron, 1986). Research on general cognitive ability has provided mixed results, however, indicating that although low intelligence scores are sometimes correlated with higher television viewing and aggression (Huesmann & Eron, 1986; Huesmann, Eron, & Yarmel, 1987), children of all cognitive abilities can be affected by exposure to violence on television (Dorr & Kovacic, 1980).

Ethnicity and social class have been of some concern in the past due to the data showing that there are differences in the amount and type of television watched by people from different social classes and of different races. Many studies have demonstrated that Blacks tend to watch more television in general than do Whites (Huston et al., 1992; Tangney & Feshbach, 1988) and more violent television in particular (Greenberg, 1974-1975). Similarly, several studies looking at differences in viewing habits by class found lower SES youths watch more television in general (Huesmann & Eron, 1986; Huston et al., 1992; Tangney & Feshbach, 1988) and more televised violence specifically (Chaffee & McLeod, 1972) than do middle and upper SES youths. Thus, whereas certain racial and economic populations may be at a higher risk because they watch more violence, there has not been much research investigating whether these populations are differentially affected by the same amount of exposure.

One factor that has been studied more extensively than others is gender. Many surveys report that boys watch more television and also more violent programs than girls. Boys also report playing more video games in general and more violent video games specifically than do girls (Funk, 1993). Finally, boys are generally more aggressive than girls (Huesmann et al., 1984). All of these initial findings have led to the hypothesis that boys may be more at risk for being affected by television violence. Earlier studies showed that boys were more affected by exposure to television violence than were girls (Eron et al., 1972); however, more recent studies seem to indicate that the development of aggression for both boys and girls is equally affected by exposure to televised violence (Bjorkqvist, 1985; Huesmann & Eron, 1986).

Finally, there has been some speculation as to whether personality differences and mental health affect one's susceptibility to violence in the media. Two early experiments found that emotionally disturbed and nondisturbed boys generally did not differ in their reactions to exposure to aggression on television (Heller & Polsky, 1976; Walters & Willows, 1968). Similarly, a study on personality, psychopathology, and video game use found no differences in personality or psychopathology for frequent versus infrequent video game players (Kestenbaum & Weinstein, 1985). Although several studies have found that "more aggressive youth were more likely than were less aggressive youth to be impacted by exposure to televised or film violence" (Dorr & Kovacic, 1980, p. 192), other studies (Huesmann, Lagerspetz, & Eron, 1984) have

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found that the strength of the longitudinal relation varied little as a function of the child's pre-existing level of aggression.

SUMMARY

The co-occurrence since World War II of increases in interpersonal violence in the United States and increases in the exposure of youths to the mass visual media has focused scientists', policy makers', and the public's attention on the possible effects of media violence on youth violence. Over the past four decades, a large body of scientific literature has emerged that overwhelmingly demonstrates that exposure to media violence does indeed relate to the development of violent behavior. The emerging theories and data suggest that multiple processes are involved, but that the most important seem to involve the observational learning of attitudes, beliefs, attributional biases, and scripts that promote aggressive behavior. Desensitization of emotional processes may also play a role in long-term effects as may a cognitive justification process in which the more aggressive children use media violence to justify their acts. At the same time, powerful shorter term effects of media violence may be engendered by excitation transfer from media violence to real life and by the tendency of media violence to cue well-learned aggressive habits. These processes would seem to place children most at-risk who already live in "a culture of violence," in which there are few norms against aggressive behavior, in which there are ethnic or nationalistic forces that support violence against dehumanized targets, and in which there is little family or educational intervention to moderate the effects of media violence. Given the robust body of literature that leads to the inevitable conclusion that viewing media violence stimulates aggressive behavior in children, future research should move beyond the simple causal issue and focus on a better understanding of the psychological processes involved and on how to inoculate children against the insidious effects of exposure to media violence.

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1998/04/28;CDC Testimony; Youth **Violence**

STATEMENT OF

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NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

CENTERS FOR DISEASE CONTROL AND PREVENTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES

COMMITTEE ON EDUCATION AND THE WORKFORCE

APRIL 28, 1998

Good afternoon Mr. Chairman. I am Dr. Rodney Hammond, Director of the Division of **Violence** Prevention of the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. I am very pleased to be here today to discuss the public health perspective on **violence** and children. I will (1) provide data about youth **violence** in our communities and schools; (2) discuss some ways we can intervene now to prevent **violence**, highlighting some specific prevention programs that work; and (3) discuss how the public health approach can contribute to the prevention of **violence**.

What We Know

Two main objectives in youth **violence** prevention are to reduce the frequency with which youth use force or resort to **violence**, and to reduce the lethality of youth **violence** which does occur. While any **violence** among children is disturbing, we should all be particularly concerned when that **violence** becomes lethal. Homicide remains the second leading cause of death for young Americans between the ages of 15 and 24 and the leading cause of death for African Americans in this age group. For children ages 10-14 years, homicide is the third leading cause of death. What has changed most dramatically over the past 20 years has been the emergence of fatal youth **violence** -- children killing children. Although there has been a slight decrease in national youth homicide rates since 1993, the number of young people who die violently remains unacceptably high, and the recent multiple shootings in schools underscores the importance of addressing youth **violence**. There was once a time when parents felt confident that their children were safe at school, but now lethal **violence** has begun to appear in schools -- a place where children unquestionably ought to be safe.

In the past several months, **violence** in schools has dominated the news and produced fear and unease in individual citizens and communities. Also in recent months, many have been shocked at the profile of those involved. In the Jonesboro, Arkansas, Paducah, Kentucky, and Pearl, Mississippi shootings, all of the perpetrators were white males of an median age of 13.5; all of the fatalities were white female of an median age of 14.5; and all of the perpetrators and victims knew each other. Just this past weekend, the news highlighted another tragedy, this time in Edinboro, Pennsylvania, where a 14 year-old-boy fatally shot a teacher and injured three others at a school dance.

We have analyzed the data relating to the recent events in Jonesboro, Paducah, and Pearl, and we also have compiled statistics from all other incidents of lethal **violence** in schools where multiple deaths occurred since 1992. Our analysis shows that whereas there were only 2 recorded multiple-death shooting events in schools between 1992 and 1995 (each involving 2 deaths), there were 9 multiple homicide events in schools between September 1995 and the present. In

addition to the cases of Jonesboro, Paducah, and Pearl, 6 other schools have experienced **violence** involving 2 or 3 deaths.

Our snapshot analysis to date is based on preliminary findings from research that the Centers for Disease Control and Prevention (CDC) has underway, in collaboration with the National School Safety Center and the Departments of Education and Justice. In conjunction with the U.S. Department of Education, we are extending our monitoring of violent, school-associated deaths in order to document whether multiple-death incidents represent an increasing trend.

Will prevention strategies that show promise in high-risk urban areas be applicable to suburban and small-town America? While we do not yet have all of the answers needed to prevent all incidents of school or community youth **violence**, we do know enough to act now. This is what we know about the problem of youth **violence**:

This is a problem of children killing children. What is so shocking about recent events is the age of the perpetrators and the victims. In recent years the average age of homicide offenders and victims has grown younger and younger, according to statistics from the Departments of Justice and Health and Human Services. More and more, instead of settling disputes with a fist-fight in the school yard children are taking out their frustrations in far more aggressive ways. Data suggest that youth **violence** has become worse -- not because children are fighting a lot more -- but because their fighting has become more lethal.

The problem is not limited to inner cities. The recent school shootings in small towns have countered the stereotype of youth **violence** as an inner-city, gang-related problem. In fact, while youth homicide rates in major urban areas have dropped in recent years, rates in mid-sized urban areas are constant or even increasing in some areas. This pattern may represent the spread of youth **violence** from our cities to rural America or this may be a totally different problem. There are enough differences in the circumstances of these incidents to warrant a closer look.

Violence in schools occurs more than any of us would like to believe. Even a single killing in or around a school is a devastating event. We need to be assured that schools are safe for our children. Although **violence** in school settings represents only a tiny fraction of all youth **violence** (less than 1% of **violence**-related deaths [homicide and suicide] among school-aged children between 1992 and 1994 occurred in or around schools), the number of multiple killings in the past 3 years is cause for grave concern. Moreover, we must check the **violence** occurring in our communities as well as in our schools. Schools and communities are linked in so many ways that it is virtually impossible to consider the problem and possible solutions in isolation. What happens inside and on the way to and from the school reflects what is happening in the surrounding community.

Homicides are only the tip of the iceberg in terms of youth **violence**. Understandably, attention focuses on the terrible tragedy of violent deaths. But there is an underlying layer of non-fatal violent behavior that should alarm us, both for its own sake and as a precursor to lethal **violence**. We do not have all of the information we need to quantify the impact of non-fatal **violence**. We do know, according to the CDC's Youth Risk Behavior Survey (YRBS) - a national survey of high school students, that in 1995, 40% of high school students reported being in at least one physical fight in the past 12 months, 20% reported carrying a weapon at least once in the previous 30 days, and more than 7% had carried a gun. More than 8% of the students reported being threatened or injured with a weapon on school property during the previous 12 months. And 1 out of 20 students was afraid to go to school at least once in the previous 30 days

because of the threat of **violence**.

These YRBS statistics should be clues that there are "early warning signs" of potentially lethal **violence**. Tracking the overall national incidence of threats, weapon carrying, and other clues to potentially violent behavior is important. In addition, it is important that we respond to threats in individual school settings. In at least two of the recent school shooting events, verbal threats reportedly preceded the killings. The threats were not reported to school officials, who might have intervened.

✓ The majority of school **violence** occurs among friends or acquaintances not strangers. A study of 1992-1994 school-associated **violence** found that 85 of the 105 deaths resulted from interpersonal disputes -- not random **violence** inflicted by a stranger. In other words, the young person's inability to manage anger, resolve inevitable adolescent conflicts, or rebound from a failed romance or rejection by friends too often fuels a violent, often lethal response. As with so many adult homicides, these school-related killings can be seen in the context of personal relationships. In each of the 3 recent multiple school shootings, all of the perpetrators knew the victims. In 2 cases, the motivation appears to have been revenge for perceived romantic rejection; in the other, the young man apparently had mocked his peers who were part of a regular prayer circle. Many promising prevention strategies focus on teaching young people how to improve their skills in managing anger and interpersonal conflict.

Schools and our society in general are ill-prepared to deal with the problem of school **violence**. We need more information to develop response plans, policies, and training to prevent **violence** in schools. As a society, we haven't yet developed the capacity to respond to the problem of kids killing kids, and we are not yet equipped to respond to the phenomenon of younger children becoming involved, as perpetrators and as victims, in homicides. In shaping an effective response, we must focus on prevention.

What Can We Do About This Problem Now?

Prevention is possible and we don't have to understand all the reasons why children commit **violence** before we take action. We know enough now to invest in solutions that can prevent future tragedies -- in schools and communities. **Violence** prevention efforts focus on changing individuals' attitudes, beliefs, and behaviors; improving the social environment of families, peers, and the community; or changing the physical environment, such as addressing access of young people to alcohol and other drugs, as well as unsupervised access to weapons. We can't expect any single action to solve the problems of youth **violence**, but over time, these approaches can make a difference.

Research undertaken by CDC and other respected researchers in the field show that there are three actions we can take now that could have a tremendous impact on our ability to prevent school **violence**: (1) increase efforts to reduce the propensity of young people to use anger or to resort to any kind of **violence** as a response to interpersonal problems; (2) use current technology to generate better information about the nature and scope of the problem and to deliver tools to parents teachers, and other community members; and (3) prevent the escalation of violent behavior into lethal actions.

Increase efforts to reduce the propensity of young people to use force or to resort to any kind of **violence** as a response to interpersonal problems. Many strategies have promise, such as parenting programs that focus on parents and young children and school-based training that enhances students' social and problem-solving skills. Recent evaluations of such programs

confirm that they do have an impact on reducing aggressive behavior and/or violent acts. A number of youth **violence** prevention projects supported by CDC have shown encouraging results. These projects have targeted predominately urban, high-risk youth and may be applicable to other areas of the country; however, these projects have not been evaluated in rural settings. Ongoing, follow-up studies on these programs will look to see if these results are appropriate for replication and continue to show promise over time. Here are some specific examples:

- Peace Builders in Tucson, Arizona, and Salinas, California, work in elementary schools to reduce physical and verbal aggression by creating a "culture of peace" within the school. Throughout the school year, counselors or other specially trained instructors, using various methods such as modeling, role play, and self-monitoring teach students to interact socially in a positive way. The main messages are to praise others, avoid insults, seek advice, and speak up about hurt feelings. The intervention has achieved significant behavioral improvement. Teachers reported an overall decline in individual problem behaviors such as fighting and destruction of property belonging to others. The follow up study will look to see if these results continue to hold up over time as the students progress through middle school.
- The University of Michigan is evaluating a three-level intervention to prevent aggressive and violent interpersonal behavior among high-risk urban youth, ages 7-13, residing in high-**violence** areas of Chicago and Aurora, Illinois. The first level consists of classroom-based training to increase awareness and knowledge about factors that influence peer and other social relationships. The next level includes activities in the first level plus training conducted through small groups and peer relationships for high risk children. And the third level adds a family intervention for the high-risk children and their families. The results show that a combination of classroom, small group and family interventions significantly reduced aggressive behavior among study participants who had demonstrated higher levels of aggression.
- In Richmond, Virginia, the Youth **Violence** Prevention Program is a school-based project to reduce aggressive behaviors among 6th graders. The 16-session curriculum teaches students how to use alternative methods to deal with **violence** and how to use adaptive methods to deal with anger. The program also has a peer mediation program that uses a problem-solving approach to reinforce the skills students learn in the curriculum. The results show significant reductions in fight-related injuries requiring medical attention, a lower frequency of threats to hurt a teacher, and significant improvements in self-esteem. Students in the program had fewer suspensions for fighting, bringing weapons to school, disruptive behavior, and defiance of school authority.
- A study of a **violence** prevention curriculum for elementary school students in Seattle, Washington, showed a positive impact in reducing aggressive physical acts and increasing pro-social behavior. The effect was modest, but combined with a growing body of evidence from other evaluated interventions, should give us hope that, just as **violence** is a learned behavior, it can be unlearned.

We have put in place some programs that work, and we know some strategies for reducing youth **violence**. However, we need a more complete response to this problem. Parents, teachers, school administrators and others need to have ready access to the best, most current, science-based information. They need the skills to identify and help children at risk so that the tragedies

of our inner cities and the tragedies of Jonesboro, Paducah and Pearl aren't repeated.

Collect and disseminate information about youth **violence**.. Although we have been able to gather some information on recent school shootings, we lack comprehensive data on violent injuries that are consistently collected over time. It is not enough just to count cases of deaths among young people. Descriptive information about the violent events is needed, such as the demographic characteristics of the people involved, the relationship between the victim and the perpetrator, and the severity and cost of the injury. A surveillance system that collects, analyzes, interprets, and disseminates such data would provide valuable information for school administrators, law enforcement officials, and other policy-makers. Experience with sound surveillance systems shows that such systems are effective tools for guiding future prevention efforts. For example, the Fatality Analysis Reporting System (FARS) has provided vital information about automobile crashes and helped guide prevention efforts in that area of injury control. We also need to provide technical assistance and state-of-the-art information about what works to parents, teachers, and other community members who need to be involved in **violence** prevention.

Prevent violent behavior from becoming lethal. While fist fights and playground scuffles are harmful, we need to embark on a constant vigil to prevent these incidents from becoming fatal. Over 85% of all violent deaths among children 10-14 years of age involve the use of a weapon. Between 1993 and 1995, if 10-14 year old children did not have unsupervised access to lethal weapons, 1,112 children might be alive today and thousands of other children may have been spared serious injury. Although homicide rates have begun to decrease, the recent school fatalities illustrate the potential for tragedy when young people have unsupervised access to lethal weapons. Children's unsupervised access to lethal weapons increases the likelihood that young people's disputes will result in death, rather than a black eye or injured pride.

In particular, firearms were used in 90% of the deaths resulting from the violent use of a weapon for 10-14 year old victims in 1993-1995. Firearm-related injuries that did not result in death are even more numerous. For example, more than 21,000 school-aged children were treated in emergency departments for firearm-related injuries in 1995. We know that the lethality of **violence** among children has increased over time, and statistics show that the increase is associated with firearms.

What Does Public Health Have to Offer?

Public health can make an important contribution to preventing youth **violence**. We all wish there were one simple solution to this problem of school **violence**. The reality is that there's no such thing. The problem is complex and the response needs to draw on the best that all sectors have to offer: education, psychology, social work, criminology, public health, medicine, and others. It is critical to provide leadership and mobilize these diverse disciplines to seek creative solutions to the problem of **violence**, and to translate what we know from science into sound prevention programs. Public health strategies can contribute significantly.

In public health, we are approaching the problem of youth **violence** by asking four questions:

- À À What is the problem? (Surveillance)
- À À What are the causes? (Research)
- À À What works to help prevent the problem? (Intervention evaluation)
- À À How do you do it? (Program implementation)

At CDC, we are addressing the problem of youth **violence** through the lens of each of these steps.

We are supporting research to identify some of the risk factors for **violence** among young people, such as the impact of economic and neighborhood characteristics, access to lethal weapons, and the influence of ethnic identity on young males. We have recently evaluated 14 youth **violence** programs around the country to determine which approaches, or combination of approaches, appear to be effective. We have briefly described the ongoing evaluations of promising programs that promote positive social environments for young children and their families. We also have produced a manual to help communities develop prevention activities -- **Prevention of Youth Violence: A Framework for Community Action** -- and are in the process of developing recommendations for "best practices" that characterize promising **violence** prevention strategies. We also are pursuing projects in the following areas:

School-based Violence Prevention. Schools need to know about effective **violence** prevention programs based on our present knowledge. The Best Practices manual that we are developing can help. There needs to be a way to communicate information about good programs systematically, including the Best Practices document, when it becomes available. Many schools have programs that are not based on the best scientific knowledge and are not being implemented as designed. In partnership with the Departments of Education and Justice, we are providing schools with guidance in selecting **violence** prevention programs. But we are just beginning to fill the needs of the schools.

Comprehensive School Health Education. Young people must acquire the skills needed to prevent future injuries and **violence**. To help state and local educational agencies and schools promote safety and teach students the skills needed to prevent future injuries and **violence**, CDC, in collaboration with other federal and national non-governmental organizations, has recently begun the process of developing evidence-based injury and **violence** prevention guidelines. The guidelines development process has been successfully employed for the topics of tobacco use prevention, HIV infection prevention, nutrition, and physical activity. It includes an extensive review and synthesis of the literature on effective program components and the creation of an expert panel to guide the process.

Communication Skills Between Parents and Schools. Parents need to see schools as a resource for help with children who exhibit problem behavior. The schools can link parents to programs in the community, but there is a gap in getting knowledge to the parents. Schools can help bridge this gap.

Parenting Skills. Parenting programs are important because the behavior of adults in the home can have an enormous influence on children. Parenting skills training can make a difference in preventing **violence** and anti-social behavior in children. Many parents need assistance to develop structured environments, and they need learn how to talk with their children about the risks of weapons and fighting.

Outreach to high-risk youth. Many youth are not accessible in traditional settings such as schools. We need to support the implementation of efforts to identify and recruit high-risk youth into programs intended to reduce the risk of **violence**.

These are but a few of the approaches that our society can take to reduce youth **violence**, including **violence** in and around schools. Our job as parents and citizens is to give children the chance to grow up in safe communities and safe schools. Our job as public health practitioners is to use science to help understand the patterns, causes, and prevention of **violence** among young people. The need to prevent these deaths is urgent, and we have the tools to begin to craft a

response.

The time to take action is now. We must turn our efforts to preventing future injury and loss of life to our young people. Along with our partners in other federal agencies, such as the Departments of Justice and Education, the public health community can make a substantial contribution to preventing **violence** among children.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions you or other members of the Subcommittee may have.

STUDYING TELEVISION VIOLENCE:

A RESEARCH AGENDA FOR THE 21st CENTURY

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Television broadcasting in the United States began on May 2nd 1941, when the Federal Communications Commission issued the first license for a commercial television station (W2XBS, NBC, Channel 1), which was to commence its licensed broadcasting on July 1st from the Empire State Building in New York City. However, the public was introduced to this new concept of television several years earlier, on April 30th 1939, when President Franklin D. Roosevelt participated in a 3-1/2 hour program on WNBT, NBC, opening the 1939 World's Fair in New York. Apparently, social scientists were not in the audience, or were not paying attention to this new phenomenon, because research on the impact of TV did not begin until almost two decades later.

Despite this delay in the scientific study of television, one of the first topics of interest to researchers and public policy specialists was the issue of television violence. The signal events for this 40-year program of research were the public hearings in the U.S. House of Representatives in 1952 and in the Senate in 1954 (United States Congress, 1952; 1955). These early expressions of concern about the issue of TV violence included testimony by a psychologist, Eleanor Maccoby of Stanford University, and a sociologist, Paul Lazarsfeld of Columbia University (Maccoby, 1954; Lazarsfeld, 1955). These two distinguished social scientists noted that there was very little research on the specific issue of the impact of TV violence, but felt that we could draw some inferences from the research that had accumulated on the influence of films (e.g., Charters, 1933; Cressey & Thrasher, 1933).

This chapter is a review of the approaches and outcomes in television violence research over the past half-century in an effort to identify opportunities to expand our knowledge in this area during the coming century. One might hope that we have addressed these issues in sufficient detail over the past 40 years to allow us to "declare victory" and move on to other topics concerning the impact of television. But, alas, much remains to be discovered about the process of effects and ways to mitigate the influence of TV violence. For example, we have moved from the early investigations that included surveys of children's viewing patterns, to more detailed studies of the impact of TV violence in laboratory-based investigations and in more natural settings using typical television programming.

However, it should not be supposed that there is a linear progression in the development of research strategies from A to Z and that Z is "better" than A. Rather, there are unique circumstances and specialized research questions for which a particular research strategy is best and there are periods in history in which some strategies are dominant because the societal questions being asked are best answered by a particular genre of research. And so, while this review begins at a particular point in history (i.e., 1950's), the description of various research paradigms will double-back time and again.

Identifying the Concern--Early Studies

To begin at the beginning with an "early theorist" on the harmful influence of media, Plato observed in *The Republic*: "Then shall we simply allow our children to listen to any story anyone happens to make up, and so receive into their minds ideas often the very opposite of those we shall think they ought to have when they are grown up?" Indeed, both Plato and Aristotle warned that we should be concerned about the ways in which a society chooses to amuse itself--they were concerned about the effects of observing violence in cockfighting and bear-baiting, but the issues are similar to media violence. So too, a more recent social commentator, Neil Postman, echoed these concerns about violence in popular media in his book, *Amusing Ourselves to Death* (1985). The persistence of these concerns about violence and popular culture is testimony to the serious nature of media violence and the "stakes" that society recognizes it has in this issue.

The early studies of television's influence began almost simultaneously in England and the United States in the mid-1950's. In England, a group of researchers at the London School of Economics and Political Science, under the direction of Hilde T. Himmelweit, a Reader in Social Psychology, began the first study of children's television viewing patterns while TV was still relatively new (only three million TV sets were installed in the 15 million households in England). This study was proposed by the Audience Research Department of the British Broadcasting Corporation (BBC) but was conducted by independent researchers and funded by a private foundation, The Nuffield Foundation. The research, begun in 1955, was published in a 1958 report, *Television and the Child: An Empirical Study of the Effect of Television on the Young* (Himmelweit, Oppenheim, & Vince, 1958).

In the United States, a similar survey of children's television viewing was undertaken by a research group at Stanford University, under the direction of Wilbur Schramm, a Professor of Communication. This study, begun in 1958, was published in a 1961 report, *Television in the Lives of Our Children* (Schramm, Lyle, & Parker, 1961). The project began with a pilot study in San Francisco, with funding from the Ford Foundation, and was later expanded, with funding from the National Educational Television and Radio Center (NETRC), to communities in Colorado and Canada that had differing levels of television access. In the main plan for this study, the researchers would contrast the patterns of daily life of children in four Colorado communities with differing levels of television exposure from "theoretically none" (Durango) to communities with multiple choices (various areas near Denver). However, research never quite works according to plan; as one of the research directors of this landmark study, Jack Lyle, described the situation:

...Wilbur (Schramm) turned to Colorado for his field study locale. With the help of the TV station's staff (KERA, Denver Public Schools television station), he identified four towns which it was anticipated would provide a range of TV available, from none to a choice of stations. Even at this date, 1959, however, this proved extremely difficult. One of the four towns was, indeed, outside of any off-air signal area but there was a primitive cable service operating in town that had a small, yet significant, subscriber base. It was anticipated, however, that TV exposure level could still be controlled by comparing kids from homes with and without cable. ...Wilbur's grand plan proved flawed as soon as he walked into the classroom in Durango, the no off-air-TV town. When he asked how many kids had watched the TV the day before, every hand was raised--and it turned out that this was not just the result of watching with a friend next door whose family had cable. Good researcher that he was, Wilbur investigated. The coaxial line used by the cable company was insufficiently shielded. The leak was so strong that if the cable came down the street, almost anyone could pick up at least a fuzzy signal and since there was no converter box, they had no difficulty with channel selection. (Lyle, 1996).

Undaunted, the researchers added some comparison towns in Canada; one in the suburbs of Vancouver,

British Columbia (where viewers received signals from both Vancouver and Seattle) and the second site 400 miles north for a true no-TV town. The result of this re-engineering was the development of a major benchmark study of children and television in the U.S. and Canada.

These two early studies set the stage for later efforts by establishing the basic paradigm of correlational research based on surveys of viewing habits and self-report, or teacher/parent report, of children's behavior. Both studies found that the time spent with television displaces time spent with other (older) media. Also, both studies found that there were differences between the television viewers and the control subjects (those who did not have access to television) in various domains. For example, Himmelweit, et al., noted: "We have found a number of instances where viewers and controls differed in their outlook; differences which did not exist before television came on the scene. There was a small but consistent influence of television on the way children thought generally about jobs, job values, success, and social surroundings." (pp.17-18). With regard to aggression, these correlational studies were less specific, as Himmelweit and her colleagues noted: "We did not find that the viewers were any more aggressive or maladjusted than the controls; television is unlikely to cause aggressive behaviour, although it could precipitate it in those few children who are emotionally disturbed. On the other hand, there was little support for the view that programmes of violence are beneficial; we found that they aroused aggression as often as they discharged it." (p. 20). In the case of the Schramm, et al., study, their conclusions about television violence included the observation that those Canadian and American children who had high exposure to television and low exposure to print were more aggressive than those with the reverse pattern. Thus, the early correlational studies or surveys identified some areas of concern about television violence and set the stage for more focused investigations. Finally, it should be noted that these 1950's studies of viewers and nonviewers took place when television was new in the U.S. and England. Later studies---in the 1970's-- would revisit these issues and this research strategy when television was being introduced into isolated communities in Australia (Murray & Kippax, 1977; 1978; 1979) and Canada (Williams, 1986; MacBeth, 1996).

Moving beyond these 1950's surveys, there was another set of studies that emerged in the early 1960's---not surveys or correlational studies but experimental studies that were addressed to cause and effect relationships in the TV violence/aggressive behavior equation. These initial experiments were conducted by two prolific researchers who were studying two distinctly different age groups: Albert Bandura, at Stanford University, conducted studies with preschool age children and Leonard Berkowitz, at the University of Wisconsin, worked with college-age youth. In both instances, the studies were experimental in design, which meant that subjects were randomly assigned to various viewing experiences and therefore the results of this manipulated viewing could be used to address the issue of causal relationships between viewing and behavior. The early Bandura studies, such as Transmission of aggression through imitation of aggressive models (Bandura, Ross, & Ross, 1961) or Imitation of film-mediated aggressive models (Bandura, Ross, & Ross, 1963), were set within a social learning paradigm and were designed to identify the processes by which children learn by observing and imitating the behavior of others. In this context, therefore, the studies used stimulus films (videotape was not generally available) back projected on a simulated television screen, and the behavior of the children was observed and recorded in a playroom setting, immediately following the viewing period. Despite the structured nature of these studies, Bandura's research was central to the debate about the influence of media violence and his popular article, What TV violence can do to your child, published in Look magazine (Bandura, 1963), ignited a firestorm of social concern.

The work of Berkowitz, such as Effects of film violence on inhibitions against subsequent aggression (Berkowitz & Rawlings, 1963) or Film violence and the cue properties of available targets (Berkowitz & Geen, 1966), studied the simulated aggressive behavior of youth and young adults following the viewing of segments of violent films, such as a Kirk Douglas boxing film, The Champion. The demonstration of

increased willingness to use aggression against others following viewing, further fueled the debate about the influence of media violence.

These early surveys of Himmelweit and Schramm and their colleagues, and the experiments of Bandura and Berkowitz and their colleagues, set the stage--in the late 50's and early 60's--for serious discussions of TV violence and established the broad paradigms that have been employed in this field through the 90's. Naturally, there have been many modifications and refinements in the later studies but these researchers and their students helped to shape the debate over the second half of the 20th century. However, although we learned much from the early studies, we have much more to learn in subsequent research.

Setting the Agenda--Public Reviews and Commentary

As the 1960's progressed, concern in the United States about violence in the streets and the assassinations of President John F. Kennedy, Martin Luther King, Jr., and Robert Kennedy stimulated continuing interest in media violence. In response, several major government commissions and scientific and professional review committees were established, from the late 1960's through the 1990's, to summarize the research evidence and public policy issues regarding the role of television violence in salving or savaging young viewers.

The five principal commissions and review panels--National Commission on the Causes and Prevention of Violence; Surgeon General's Scientific Advisory Committee on Television and Social Behavior; National Institute of Mental Health Television and Behavior Project; Group for the Advancement of Psychiatry Child and Television Drama Review; and the American Psychological Association Task Force on Television and Society--have been central to setting the agenda for research and public discussion.

Violence Commission:

The formal expressions of concern progressed from the 1950's Congressional hearings on television and juvenile delinquency to the establishment of the National Commission on the Causes and Prevention of Violence by President Lyndon Johnson (Executive Order 11412) on June 10, 1968 and its extension by President Richard Nixon (Executive Order 11469) on May 23, 1969.

The "Eisenhower Commission" (so called because it was chaired by Milton Eisenhower, a distinguished university president and the brother of former President Dwight Eisenhower) concluded its review and issued a final report in December 1969. One of the 15 reports (Volume 9) was devoted to the topic of Mass Media and Violence (Baker & Ball, 1969). In this report, the Commission staff members provided summaries of research issues and appended the reports of commissioned reviews of the literature or special studies undertaken for the program.

Among the special studies for the Eisenhower Commission were surveys of public opinion about-- and experience with--violence, conducted by Louis Harris and Associates Inc.. In addition, the report included a study of the content of television programming conducted by George Gerbner and his colleagues at the Annenberg School of Communications at the University of Pennsylvania. This approach by the Commission added a new set of research techniques and a new frame of reference for the discussions of TV violence. For example, the Harris (1969) poll found that there was a similarity between those who held norms that approved of the use of violence (the "approvers") and those who had first-hand experience with real-life violence as either victims, assailants or observers (the "violents"). So too, the analysis of television content (Gerbner, 1970) found that 81% of the programs studied in 1967

and 1968 (prime time and Saturday morning) contained some form of violence. Indeed, in the case of "content analysis" and interpretation, the Commission initiated a line of research on television that was to prove central to all future discussions of this topic. This research tradition is manifested in more recent, although modified, approaches to content analysis conducted for the cable television industry (Mediascope, 1996) and broadcast network television (UCLA Center for Communication Policy, 1995).

Surgeon General's Study:

On 3 June 1969, while the Violence Commission was developing its final report, the Secretary of the Department of Health, Education and Welfare, Robert Finch, announced the establishment of the Surgeon General's Scientific Advisory Committee on Television and Social Behavior with a mission to: "study the effects of television on social behavior, with its focus on the effects of televised violence on the behavior, attitudes, development, and mental health of children; the study is to be confined to scientific findings and the committee will make no policy recommendations." (Surgeon General's Scientific Advisory Committee on Television and Social Behavior, 1972, p. 139).

This new committee resulted from testimony by Surgeon General William Stewart on 12 March 1969, before the U.S. Senate Subcommittee on Communications. In his testimony, Surgeon General Stewart noted that the task of assessing television violence: "cannot be accomplished by narrowly focused studies, since the violence a child sees on television is randomly interwoven into the total skein of television fare...it is essential to recognize that, with such a complex phenomenon, all the answers will not be forthcoming within the next few weeks or the next few months. The panel's findings and recommendations should be an important step in increasing our understanding of our social environment and of ourselves." (p.139).

One of the major accomplishments of the Surgeon General's study was the ability to keep faith with Surgeon General Stewart's views by commissioning almost 60 studies by more than 80 researchers throughout the U.S. and several other countries. The end result was a concentrated study of TV violence by researchers drawn from multiple disciplines (e.g., psychology, education, sociology, communications, psychiatry, anthropology and political science), using diverse methodological approaches (e.g., surveys, content analysis, laboratory experiments, field studies, and cultural contrasts), and studying viewers in diverse ages and stages of development. This was not only the first time that such a focused study was undertaken, but also the first time that these diverse studies would be reviewed by a panel of 12 social scientists and clinicians who had expertise in research, mental health and education practice, and the communications industry.

The committee members were drawn from both academic and professional settings because the Surgeon General felt that approach worked in the earlier studies of smoking and health. The 12 members and their affiliations were: Ira H. Cisin, George Washington University; Thomas E. Coffin, National Broadcasting Company; Irving L. Janis, Yale University; Joseph T. Klapper, Columbia Broadcasting System; Harold Mendelsohn, University of Denver; Eveline Omwake, Connecticut College; Charles A. Pinderhughes, Boston University; Ithiel de Sola Pool, Massachusetts Institute of Technology; Alberta E. Siegel, Stanford University; Anthony F.C. Wallace, University of Pennsylvania; Andrew S. Watson, University of Michigan; and Gerhart D. Wiebe, Boston University. The committee was chaired by Eli A. Rubinstein, Deputy Director of the National Institute of Mental Health, who was Vice Chairman and representative of the Surgeon General. In addition, the Secretary of Health, Education and Welfare appointed a direct representative, Richard A. Moore, a former general manager of a Los Angeles television station.

This committee structure was innovative but not without considerable controversy. In particular, concerns were expressed that there were too many committee members with ties to the television industry

that might influence the interpretation of research findings and Committee recommendations (see, Cater & Strickland, 1975). In the end, the committee members, under strenuous urging by Eli Rubinstein, unanimously agreed to a committee report that, while cautious, did conclude that viewing TV violence can lead to increases in children's aggressive behavior (Murray, 1973; Rubinstein, 1974).

One of the unexpected outcomes of the Surgeon General's study was the expansion of support for studies of the impact of television. For example, bibliographies of research and commentary on the topic of television and behavior chronicled a marked increase in publications on this topic from 285 in 1971 (Atkin, Murray, & Nayman, 1971), to about 1,200 in 1975 (Comstock & Fisher, 1975), to almost 3,000 in 1980 (Murray, 1980). There was some slowing of the growth in publications in the 1980's (Wartella & Reeves, 1984) but the cumulative impact of the Surgeon General's study can be felt into the 1990's (Huston, Donnerstein, Fairchild, Feshbach, Katz, Murray, Rubinstein, Wilcox, & Zuckerman, 1992). Much of the strength and diversity of research on TV violence--and the establishment of a research agenda--is directly attributable to the impetus of the Surgeon General's Scientific Advisory Committee on Television and Social Behavior.

NIMH Study:

In 1982, the National Institute of Mental Health (NIMH) published a 10 year follow up of the 1972 Surgeon General's study. That two volume report (National Institute of Mental Health, 1982; Pearl, Bouthilet, & Lazar, 1982), collectively entitled *Television and Behavior: Ten Years of Scientific Progress and Implications for the Eighties*, provided a reminder of the breadth and depth of knowledge that has accumulated on the issue of TV violence--although the NIMH report was not focused solely on violence. However, with regard to TV violence, the NIMH staff and consultants concluded:

After 10 more years of research, the consensus among most of the research community is that violence on television does lead to aggressive behavior by children and teenagers who watch the programs. This conclusion is based on laboratory experiments and on field studies. Not all children become aggressive, of course, but the correlations between violence and aggression are positive. In magnitude, television violence is as strongly correlated with aggressive behavior as any other behavioral variable that has been measured. The research question has moved from asking whether or not there is an effect to seeking explanations for the effect. (National Institute of Mental Health, 1982, p. 6)

The release of the NIMH report caused some concern in the television industry (Wurtzel & Lometti, 1983) but it was generally supported by knowledgeable researchers. For example, in a survey conducted shortly after the release of the NIMH report (Murray, 1984), the majority of the 109 psychologists, sociologists and communications researchers strongly agreed with the NIMH conclusions. Moreover, an earlier study of 468 communication professionals (Bybee, Robinson & Turow, 1982) found strong support for the proposition that television violence is causally related to aggressive behavior in children.

The GAP Report:

The Group for the Advancement of Psychiatry (GAP) is an organization established in 1946 to foster innovation and interdisciplinary reviews of issues in mental health and human relations. In 1982, the Committee on Social Issues of GAP, chaired by Roy W. Menninger, undertook a review of the role that television plays in the socialization of young children. This report, *The Child and Television Drama: The Psychosocial Impact of Cumulative Viewing*, provided an overview of the research and professional insights that have accumulated from the National Commission on the Causes and Prevention of Violence through the Surgeon General's study and the NIMH report. In the concluding section of their report, the

GAP committee elaborated a series of recommendations for parents, mental health professionals, public policymakers, and the television industry. One of the recommendations to the television industry is particularly relevant to the issue of violence and the portrayal of conflict:

Television dramas ought to reconfirm the reality that human behavior is complex, that motivations are many, and that the personal and social problems to be solved have many answers. In this vein drama should not portray human conflict as responsive to simple solutions, simple choices, snap decisions, or violence. Drama should reinforce the fact that no human being is free from anxiety, immune to conflict, or likely to live happily ever after. (Group for the Advancement of Psychiatry, 1982, p. 118)

Many of the GAP report recommendations urge a more collaborative spirit in the search for solutions to this historic concern about media violence and violence in society. The GAP report helped to move professional discussions from research findings to the development of practical guidelines for positive mental health practices in programming--a theme that has been revisited in later reports from the Institute for Mental Health Initiatives (Livingstone, 1994) and the OKTV Foundation (1995).

APA Report:

In 1986, the American Psychological Association (APA) impaneled a Task Force on Television and Society to review the research and professional concerns about the impact of television on children and adults. One specific charge was:

Review and integrate existing research on the positive and negative effects of television advertising and programming on particular segments of the United States population, specifically women, children, minorities, and the elderly. Emphasize research since the 1982 report from the National Institute of Mental Health, which updated the 1972 Report of the Surgeon General's Scientific Advisory Committee on Television and Social Behavior.

The nine psychologists assigned to this committee undertook reviews of relevant research, conducted interviews with television industry and public policy professionals, and discussed concerns with representatives of government regulatory agencies and public interest organizations. The final report, entitled *Big World, Small Screen: The Role of Television in American Society* (Huston, Donnerstein, Fairchild, Feshbach, Katz, Murray, Rubinstein, Wilcox & Zuckerman, 1992) included the following observation about television violence:

American television has been violent for many years. Over the past 20 years, the rate of violence on prime time evening television has remained at about 5 to 6 incidents per hour, whereas the rate on children's Saturday morning programs is typically 20 to 25 acts per hour. There is clear evidence that television violence can cause aggressive behavior and can cultivate values favoring the use of aggression to resolve conflicts. (p. 136)

The report ends with a plea to the television industry and government to rethink and renew our commitment to enhancing children's television, noting: "Our failure to realize the potential benefits of the medium is perhaps more significant than our inability to control some of its harmful effects." (p. 145) They speculate that if we were to devote efforts using TV to stimulate their minds, stretch their horizons, and teach them about the world we might find that this educational and entertaining programming would displace some of the violence that children experience.

Exploring the Issue--Paradigms for Studying TV Violence

Over the past half century, about 1,000 reports have been published on the issue of TV violence. Of course, only a small percentage of these thousands of pages represent original studies or research reports, but there is an extensive body of research on the impact of TV violence.

Throughout this history of concern, there have been diverse questions raised about the extent of TV violence and the nature and scope of its impact. Social scientists have employed three broad strategies to answer questions about prevalence, correlation, and causation. Questions about the prevalence of television violence have been addressed by content analysis of selected broadcast periods. Questions about the correlation between TV violence viewing and aggressive behavior have been addressed by surveys of viewing patterns in relation to viewers' attitudes or overt behavior. Questions about causation of aggressive behavior by TV violence viewing have been addressed in experiments conducted in either laboratory or field settings. These three approaches, and the exemplary studies outlined below, provide an overview of the major findings and concerns about TV violence.

Prevalence:

One of the earliest studies of television content was the work of George Gerbner and his colleagues at the Annenberg School of Communications at the University of Pennsylvania. These analyses were begun in conjunction with the National Commission on the Causes and Prevention of Violence (Gerbner, 1970) and the Surgeon General's Scientific Advisory Committee on Television and Social Behavior (Gerbner, 1972) and they have continued annually through the 1990's (e.g., Gerbner, Gross, Morgan, & Signorielli, 1994).

In the typical study, Gerbner and his colleagues would video tape all evening, prime-time, television programming and all Saturday morning television programs broadcast or cablecast during one week following the advent of the new TV season in the Fall of each year. The analysis of these programs includes an extensive coding of the frequency and nature of violence portrayed. Violence is not the only issue addressed in Gerbner's "Cultural Indicators" program but violence is important because it is a "definer of power" in the sense that those who are the victims of violence are usually portrayed as powerless. Thus, Gerbner's analyses extend beyond mere body counts and describe the social structure of violence. In this regard, these studies often find that those who commit violence are frequently white males, in their 20's or 30's while those who are the victims of this violence are often female, nonwhite, elderly and foreign born.

With regard to the prevalence of violence, Gerbner (1972) found that eight out of ever 10 plays broadcast during their survey period in 1969 contained some form of violence. Similar studies conducted each year have documented consistently high levels of violence. Figure 1 displays the annual reports on the percentage of prime-time programs containing violence on the three major networks (ABC, CBS, NBC) and the newer FOX network, from 1973 to 1995. It can be seen that the average for the three major networks is about 70% of all programs with peaks at 80% and several drops to around 60%, or even 50%.

Percent of Programs with Violence in Three Major Networks and Fox

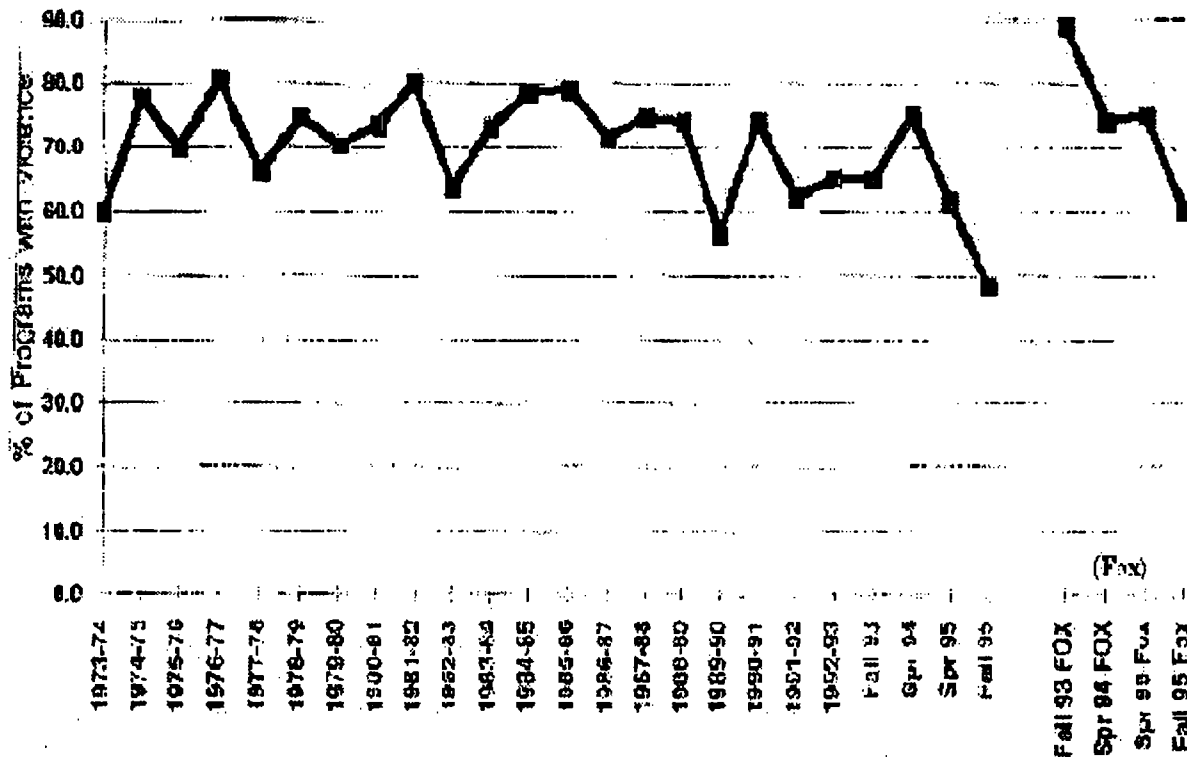


Figure 1: Trends in the level of violence on four U.S. television networks 1973-95. (Source: Gerbner, 1997)

These drops or "valleys of violence" usually correspond to years in which there was significant public "outcry" about media violence (e.g., 1973-74 following the 1972 release of the Surgeon General's report on the harmful effects of TV violence; 1982-83 following public concern about the bloody 1981-82 season which saw an all-time peak in the number of violent acts on children's Saturday morning television--about 31 acts per hour; and drops in 90 and 95 following Congressional hearings on the Children's Television Act and continuing congressional and FCC hearings concerning the V-Chip and educational programming)--even the very violent FOX network dropped from 90% to 60% from 93 to 95. Nevertheless, over almost a quarter century of yearly monitoring of TV violence levels, this analysis has found the average level of violence in prime time holding at about five violent acts per hour, while children's weekend morning programming has averaged around 25 violent acts per hour.

Other studies designed to assess the prevalence of TV violence have found even more worrisome levels of mayhem. In 1992, the Center for Media and Public Affairs (Lichter & Amundson, 1992) monitored one day (6:00 a.m. to midnight) of television fare available on broadcast and cable channels in Washington, DC. This analysis recorded 1,846 violent scenes during this one 18-hour period on an April day in 1992. Moreover, a follow-up study (Lichter & Amundson, 1994) in 1994 found 2,605 violent scenes in a similar 18-hour day--a 41% increase from 92 to 94.

Continuing studies of the prevalence of TV violence have included more qualitative approaches to this issue. The UCLA Center for Communication Policy (1995), in a study funded by the commercial television networks, concluded: "The world of television, from broadcast networks, to syndication, to cable, to home videos, is not as violent as we had feared and not as wholesome as we might have hoped. There is room for substantial improvement" (p. 151). At the same time, other studies (Mediascope, 1996), funded by the National Cable Television Association, found evidence of fairly extensive levels of violence on both broadcast and cable television based on their analysis of a 20-week composite involving 2,693 programs on 23 channels. The Mediascope results showed that the percentage of programs containing violence on the broadcast network stations was 44%; while the figure for independent broadcast stations was 55%; basic cable stations logged 59%; premium cable subscription channels had violence in 85% of the programs; and public television had violence in only 18% of its programming. And, once again, this most recent study reconfirmed that there were ethnic and gender differences in TV violence; the typical perpetrator of violence is adult (76%), male (78%), and Caucasian (76%). Also, the context of the violence includes the observation that 90% of movies contain violence and 67% of the violence in children's programs is set in a humorous context--indeed, only 5% of the violence in children's programming portrays any long-term negative consequences of the violent acts.

Clearly, the studies of prevalence of TV violence, indexed by content analysis of programming, demonstrate pervasive and persistent levels of violence in television entertainment. The various studies have used somewhat different approaches to sampling: one week, prime time and Saturday morning (Gerbner & Gross, 1976a; 1976b); one 18-hour day (Lichter & Amundson, 1992; 1994); and a composite 20-week period (Mediascope, 1996). Nevertheless, the overall conclusions from these diverse studies are similar in demonstrating extensive violence in television programming. The next step in assessing TV violence is to move from studies of prevalence to studies of impact by demonstrating a relationship between viewing violence and aggression.

Correlation:

The demonstration of a relationship between viewing and aggressive behavior is a logical precursor to studies of the causal role that TV violence may play in promoting aggressive behavior. However, as discussed in the earlier section on the history of concern about TV violence, the correlational or survey studies assessing real-world relationships developed almost simultaneously with experiments designed to assess the causal influences of viewing violence. Nevertheless, it is important to keep the correlation vs causation approaches separate because they represent different paradigms with different logical interpretations and implications. In these correlational studies, the issue of causation is not relevant--rather, the emphasis is on the co-occurrence of viewing and aggression.

The early surveys of the impact of television on children, conducted by Himmelweit, et al. (1958) and Schramm, et al. (1961)--discussed in an earlier section--addressed some of these concerns about violence. However, later research was more focused in studying the correlations between TV violence viewing and aggression.

In typical correlational studies, such as those conducted for the Surgeon General's research program (McLeod, Atkin & Chaffee, 1972a; 1972b; Dominick & Greenberg, 1972; Robinson & Bachman, 1972) the researchers found consistent patterns of significant correlations between the number of hours of television viewed or the frequency of viewing violent programs and various measures of aggressive attitudes or behavior. In a later study, Atkin, Greenberg, Korzenny and McDermott (1979) found that heavy TV-violence viewers were more likely to choose physical and verbal aggressive responses to solve hypothetical interpersonal conflict situations (i.e., 45% of the heavy violence viewers chose physical/verbal aggressive responses vs. 21% of the low violence viewers). Similarly, a more recent study

in this genre (Walker & Morley, 1991) found that adolescents who reported enjoying TV violence were more likely to hold attitudes and values favorable to behaving aggressively in conflict situations.

A somewhat different set of correlational studies was designed to assess subtle shifts in attitudes and behavior that might only be observed in large samples of the population. Two studies in this genre, conducted by David Phillips (1982;1983) at the University of California at San Diego, assessed the effect of television on adult fatalities. In one study, Phillips used national Death Certificate records compiled by the U.S. Centers for Disease Control to evaluate the impact of televised suicides portrayed in "soap operas" on the incidence of suicide in the U.S. population. He found that whenever a major suicide (i.e., suicide of a main character) occurred in a soap opera in the 1960's, there was a significant increase in the national incidence of suicide by women (a major audience for soap operas in those days), within three days of the telecast. Similarly, a second study found that the telecast or cablecast of a major boxing event was related to a significant increase in death by homicide for men (a major audience) who were similar in age and ethnicity to the loser of the boxing match. Phillips (1983) suggests that television portrayals can stimulate subtle changes in attitudes that might make a particular behavior or course of action, such as suicide, seem more acceptable to viewers because it is portrayed as acceptable for the television performers.

In a similar vein, another large database, the Cultural Indicators Project, has been used to explore the relationship between television portrayals and the viewer's conception of the world. In a series of studies begun in 1974, George Gerbner and his colleagues (Gerbner, Gross, Morgan, & Signorelli, 1994) at the University of Pennsylvania have tracked public perceptions of society in relation to the respondent's extent of television viewing. Of relevance to the violence issue, these researchers have identified differences in the risk-of-victimization perceptions, described as the "mean world syndrome" effect, of light vs. heavy viewers. The heavy viewers (usually, 5 or more hours per day) are much more fearful of the world around them than are light viewers (about 3 or fewer hours per day). When questioned about their perceptions of risk, heavy viewers are much more likely to overestimate (i.e., greater than the FBI crime reports for their locale would suggest) the chance that they will be the victim of crime in the ensuing six months, have taken greater precautions by changing the security of their homes or restricting their travels at night and are generally more fearful of the world. As Gerbner et al. (1994) note: ...we have found that long-term exposure to television, in which frequent violence is virtually inescapable, tends to cultivate the image of a relatively mean and dangerous world...in which greater protection is needed, most people cannot be trusted,' and most people are just looking out for themselves' (p30). This cultivation analysis, conducted over the past 30 years, has evolved into a new concept of evaluating the accuracy of portrayals of various social groups--the "Fairness Index" which will be applied to a entire season of programming in a forthcoming report for the Screen Actors Guild (Gerbner, 1997).

Studies such as these clearly demonstrate that violence viewing and aggressive behavior are related but they do not address the issue of cause-and-effect. And yet, there are some special correlational studies in which "intimations of causation" can be derived from the fact that these studies were conducted over several time periods. There have been three major "panel" studies: A study funded by CBS (Belson 1978), one funded by NBC (Milavsky, Kessler, Stipp, & Rubens, 1992), and the third funded by the Surgeon General's Committee and NIMH (Lefkowitz, Eron, Walder, & Huesmann, 1972; Huesmann, Eron, Lefkowitz, & Walder, 1984; Huesmann & Eron, 1986).

The CBS study (Belson, 1978) was conducted in England with 1,565 youths who were a representative sample of 13 to 17 year old males living in London. The boys were interviewed on several occasions concerning the extent of their exposure to a selection of violent television programs broadcast during the period 1959 through 1971. The level and type of violence in these programs were rated by members of the BBC viewing panel. Thus, it was possible to obtain, for each boy, a measure of both the magnitude

and type of exposure to televised violence (e.g., realistic, fictional, etc.). Furthermore, each boy's level of violent behavior was determined by his report of how often he had been involved in any of 53 categories of violence over the previous six months. The degree of seriousness of the acts reported by the boys ranged from only slightly violent aggravation, such as taunting, to more serious and very violent behavior such as: "I tried to force a girl to have sexual intercourse with me"; "I bashed a boy's head against a wall"; "I burned a boy on the chest with a cigarette while my mates held him down;" and "I threatened to kill my father." Approximately 50% of the 1,565 boys were not involved in any violent acts during the six-month period. However, of those who were involved in violence, 188 (12%) were involved in 10 or more acts during the six-month period. When Belson compared the behavior of boys who had higher exposure to televised violence to those who had lower exposure (and had been matched on a wide variety of possible contributing factors), he found that the high-violence viewers were more involved in serious interpersonal violence.

The NBC study (Milavsky, Kessler, Stipp, & Rubens, 1982) was conducted over a three year period from May 1970 to December 1973 in two cities, Fort Worth and Minneapolis. Interviews were conducted with samples of second- to sixth-grade boys and girls and a special sample of teenage boys. In the elementary school sample, the information on television viewing and measures of aggression were collected in six time periods over the three years. The aggression measure consisted of peer ratings of aggressive behavior based on the work of Eron and his colleagues (Eron, Walder, & Lefkowitz, 1971). In the teenage sample there were only five waves of interviews over the three years and the aggression measures were self-report rather than peer-reported aggression. In summarizing the results of this study, the authors concluded: "On the basis of the analyses we carried out to test for such a causal connection there is no evidence that television exposure has a consistently significant effect on subsequent aggressive behavior in the [elementary school] sample of boys." (Milavsky, et al., 1982, p.482). Similar null findings were reported for the elementary school girls and the teenage boys. However, re-analysis of these data by Kenny (1984) and Cook and his associates (Cook, Kendzierski, & Thomas, 1983) have concluded that there are small but clear causal effects in the NBC data and that these effects become stronger when analyzed over longer time periods through successive waves of interviews.

Finally, one of the longest panel studies, 22 years, is the work of Leonard Eron and his colleagues (Eron, 1963; Lefkowitz, Eron, Walder & Huesmann, 1972; Eron, 1982; Huesman, Eron, Lefkowitz & Walder, 1984; Huesmann & Eron, 1986). In the initial studies, conducted for the Surgeon General's investigation of TV violence (Lefkowitz, et al., 1972), the researchers were able to document the long-term effects of violence viewing by studying children over a 10-year period from age 8 to age 18. At these two time periods, the youngsters were interviewed about their program preferences and information was collected from peer ratings of aggressive behavior. The violence levels of their preferred TV programs and measures of aggression across these two time periods suggested the possibility that early television violence viewing was one factor in producing later aggressive behavior. In particular, the findings for 211 boys followed in this longitudinal study demonstrated that TV violence at age 8 was significantly related to aggression at age 8 ($r = .21$) and the 8-year old violent TV preferences were significantly related to aggression at age 18 ($r = .31$) but TV violence preferences at age 18 were not related to aggressive behavior at the earlier time period, age 8 ($r = .01$). When other possible variables, such as parenting practices and discipline style, were controlled (e.g. partial correlation) it was still clear that early media violence could be part of the cause of later aggressive behavior. Furthermore, in a follow-up study, when these young men were now age 30 (Huesmann, Eron, Lefkowitz & Walder, 1984), the authors found a significant correlation ($r = .41$) between TV violence levels at age 8 and serious interpersonal criminal behavior (e.g., assault, murder, child abuse, spouse abuse, rape) at age 30.

Thus, it seems clear that a correlation between television violence and aggression can be established from diverse studies. And, some special cases of longitudinal correlational studies (described as

cross-lagged/panel studies) can lead to intimations of causation. However, the issue of causation is best assessed in experimental designs that allow for random assignment of subjects to various treatment conditions or, in the case of field studies, take advantage of naturally occurring variations in television viewing experiences.

Causation:

The potential role of television violence in the causation of aggressive behavior was, as noted earlier, among the first topics investigated by social scientists. The studies by Bandura (e.g., Bandura, Ross & Ross, 1961; 1963) and Berkowitz (e.g., Berkowitz & Rawlings, 1963) set the stage for later experimental studies in which causal influences of TV violence could be assessed by randomly assigning subjects to various viewing conditions. These later studies employed both the structured, laboratory-based, settings as well as more naturalistic settings in schools and communities.

One of the earlier studies in this genre (Liebert & Baron, 1972), assessed the effects of viewing segments of a violent television program, *The Untouchables*, on the aggressive behavior of 5-9 year old boys and girls. In this study, the children viewed either *The Untouchables* or a neutral, but active, track race. Following viewing, the child was placed in a playroom setting in which he or she could help or hurt another child who was ostensibly playing a game in another room. The subject could help the other child by pressing a button that would make the game easier to play and allow the other child to win more points. Similarly, the child could hurt the other child by pressing a button that would make the game very difficult play and hence lose points. The results indicated that youngsters who had viewed the violent program manifested a greater willingness to hurt the other child than youngsters who had watched the neutral program. Moreover, an elaboration of this study by Paul Ekman and colleagues (Ekman, Liebert, Friesen, Harrison, Zlatchin, Malmstrom, & Baron, 1972) included the recording of the facial expressions of these children while they were watching the television violence. In this instance, the children whose facial expressions indicated interest or pleasure while watching TV violence were more willing to hurt the other child than the youngsters whose facial expressions indicated disinterest or displeasure while watching TV violence. Thus, this set of studies identified some potential moderating variables in the violence-viewing/aggressive-behavior equation.

Other early experiments by researchers using physiological measures of arousal (e.g., GSR, heart rate, respiration changes) while watching violent cartoons (Osborn & Endsley, 1971; Cline, Croft & Courier, 1973) found that children are emotionally responsive to even animated violence. So too, other studies (Ellis & Sekyra, 1972; Hapkiewicz & Roden, 1971; Lovaas, 1961; Mussen & Rutherford, 1961; Ross, 1972) found that exposure to even one violent cartoon leads to increased aggression in the structured playroom settings. Furthermore, studies by Drabman and his colleagues (Drabman & Thomas, 1974; Thomas, Horton, Lippincott & Drabman, 1977) have shown that children who view violent television programs become desensitized to violence and are more willing to tolerate aggressive behavior in others. Moreover, later studies with emotionally disturbed children (Gadow & Sprafkin, 1993; Grimes, Cathers & Vernberg, in press) have found that these youngsters may be more vulnerable to the influence of TV violence. For example, Grimes et al. (in press) found that 8 to 12 year-olds who were diagnosed as having either attention-deficit-hyperactivity disorder, oppositional defiant disorder, or conduct disorder, manifested less emotional concern for victims and were more willing to accept violence as justified than a matched group of children who did not have these disorders.

All of the studies described above were conducted in fairly structured laboratory or playroom settings where the display of aggression, emotional arousal, or desensitization were relatively contiguous to the viewing of TV violence. Questions remain about what might happen in more naturalistic settings or field studies of violence viewing and aggressive behavior. One early study that assessed these issues in was the

work of Aletha Huston, now at the University of Texas, and her colleagues (Stein & Friedrich, 1972; Friedrich & Stein, 1973) in which they assessed the impact of viewing aggressive vs. prosocial television programs on the behavior of preschoolers in their normal child-care settings. In this study, the preschoolers were assigned to view a diet of either Batman and Superman cartoons, or Mister Rogers' Neighborhood, or neutral programming that contained neither aggressive or prosocial material (i.e., special travel stories for preschoolers). The "diet" consisted of 12 half-hour episodes that were viewed one half-hour per day, three days per week, for three weeks. The researchers observed the children in the classroom and on the playground for three weeks prior to the start of the viewing period, to establish a baseline for the amount of aggression or prosocial behavior, and continued to observe the children during the four weeks of viewing and for an additional two weeks. The results were that children who were initially more aggressive and had viewed the diet of Batman and Superman cartoons were more active in the classroom and on the playground, played more roughly with toys, got into more aggressive encounters. Conversely, youngsters from lower income families who had viewed the Mister Roger's diet increased their prosocial helping behavior. One suggestion from this early field study is that viewing aggressive program content can lead to changes in aggressive behavior, while the opposite is also true for prosocial programming. Moreover, these changes were demonstrated in a relatively short viewing period (12 half hours) and in the context of other viewing that took place outside of the classroom setting.

Other field studies have used restricted populations such as boys in detention centers or secure residential settings. In one such study, conducted for NBC, Feshbach and Singer (1971) presented preadolescent and adolescent males in a security facility with a diet of aggressive or nonaggressive television programs over a six week period and measured their daily aggressive behavior. They found that the youngsters who watched the nonaggressive programs were more aggressive than the other group. However, this study was criticized on methodological grounds relating to the selection of subjects and the assignment of viewing conditions (Liebert, Sobel & Davidson, 1972) and a subsequent replication (Wells, 1973) failed to duplicate the findings. Moreover, a later study conducted by Berkowitz and his colleagues (Parke, Berkowitz, Leyens, West & Sebastian, 1977), using aggressive or nonaggressive films presented to adolescent males living in minimum security institutions, did demonstrate increases in both verbal and physical interpersonal aggression among the teens viewing the aggressive diet.

Another approach to field studies involved the assessment of the effects of naturally occurring differences in the television exposure available to children in communities with or without television or communities with differing television content. In one set of studies (Murray & Kippax, 1977; 1978) the researchers were able to study the introduction of television in a rural community in Australia, in contrast to two similar communities that had differing experiences with television. In a second set of studies (Williams, 1986; Macbeth, 1996), the research team studied the introduction of television in a rural Canadian community, in contrast to two similar communities with differing television experience. In general, the results of both the Australian and Canadian studies converge in showing that the introduction of television has a major influence on restructuring the social lives of children in these rural communities. In this regard, both studies found that television displaces other media use and involvement in various social activities--not dissimilar to the earlier studies of children in England (Himmelweit, et al., 1958) or the U.S. and Canada (Schramm, et al., 1961). However, with regard to the effects of TV violence, these newer field studies provide stronger evidence of negative influence, in differing but complementary ways.

In one stage of the Australian study (Murray & Kippax, 1977; 1978; Murray, 1980), the researchers interviewed 8 to 12 year old children about their conceptions of crime as a way of examining the global influence of the television content that varied across the three Australian towns. The initial study assessed the effects of the introduction of television in one town (the No-TV town) by contrasting the residents' behavior and attitudes with that in two similar towns with differing television experience (Low-TV--two years experience with only public television vs. High-TV--five years experience with both public and

commercial television). At the next wave of data collection (2 years later), the No-TV town had acquired television (now the New-TV town) and the other towns had, respectively, 4 and 7 years experience. The authors reasoned that the High-TV town should show a more differentiated conception of crime because it was the only town with extensive exposure to action-adventure, crime-police dramas. To test this hypothesis, children were presented with a selection of several illegal activities (spying, murder, drunkenness, assault, kidnapping, bank robbery and shoplifting).

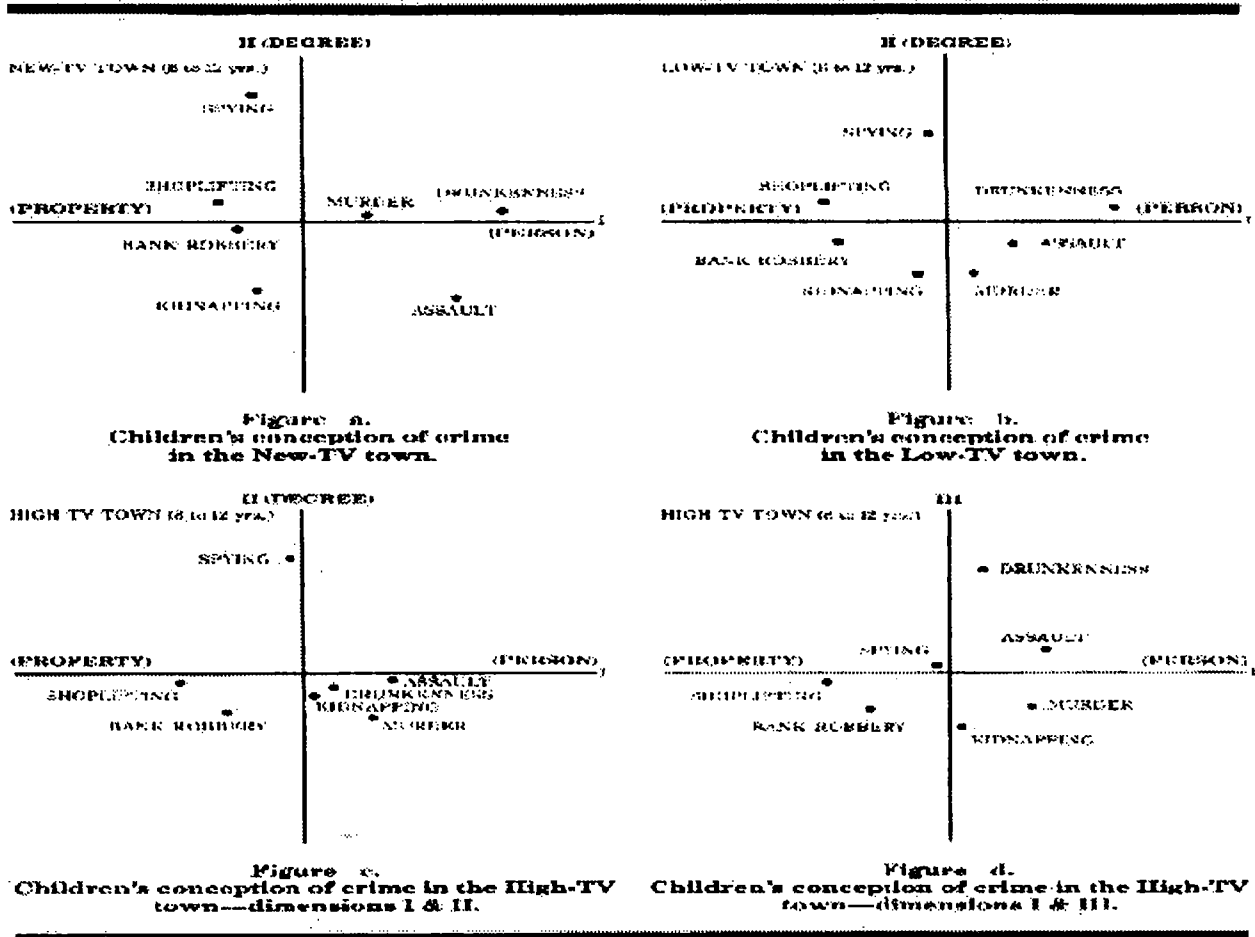


Figure 2: Children's conception of crime in three Australian towns with differing television programming. (Source: Murray, 1980)

The items were presented in pairs and repeated so that each item was paired with every other item. For each pair, the child was asked to rate the similarity of these two crimes on a five-point scale from very much alike to not at all alike. Multidimensional scaling analysis was employed to extract the children's conceptual structure of criminal activity. The results in Figure 2 are the plots of the multidimensional conception of crime across the three towns. It can be noted in sections a and b that the children in the New-TV and Low-TV towns produced a straightforward two-dimensional conception of the structure of crime. The two dimensions appear to be the degree of seriousness of the crime and a property vs. person dimension. However, in sections c and d of Figure 2, it can be seen that the children in the High-TV town (seven years experience with the more violent commercial television) produce a much more differentiated conception of crime consisting of three dimensions. The first two dimensions are similar to the other two towns, namely, seriousness and property vs. person. But, the children in the High-TV town overlay these

dimensions with a third dimension that may be related to the frequency with which these crimes occur in real life and on television. The possibility that this third dimension is a melange of the real and televised worlds is suggested by the ordering of drunkenness, spying, and shoplifting. Thus, the children in the High-TV town had a much more complex conception of crime than their peers in either the Low-TV or New-TV towns.

In the other community-level analysis of the impact of television, the study of children in three Canadian communities (Williams, 1986; MacBeth, 1996; 1997), the authors found that the introduction of television in a community led to increases in aggressive behavior. In this instance, the researchers compared children living in the before/after television town (Notel) with their peers in two other towns where television was well established: Unitel (receiving the government-owned commercial channel, CBC) and Multitel (receiving both the CBC and three American commercial networks--ABC, CBS and NBC). Children in all three towns were evaluated at Time 1 when Notel did not receive a television signal, and again at Time 2, after Notel had television for two years. The results of this phase of the study demonstrated that there were no differences across the three towns at Time 1, but at Time 2 the children from the former Notel were significantly more aggressive, both physically and verbally, than the children in the Unitel or Multitel towns. Moreover, only children in the Notel town manifested any significant increase in physical and verbal aggression from Time 1 to Time 2. The authors concluded that it is particularly striking that: "...the effects of television were not restricted to a subset of children. Boys and girls, children initially high and low in aggression, and those watching more or less TV were equally likely to show increased aggressive behavior [in the Notel town]" (Joy, Kimball & Zabrack, 1986, p.239).

In conclusion, it seems clear that laboratory experiments and field studies converge in suggesting that television violence is implicated in the production of aggressive attitudes, values and behavior--Not all children are affected, not all children are influenced to the same extent but television violence can lead to increases in aggression. The questions that remain are questions about the process of effects and the nature of interventions that might mitigate the influence of televised violence on young viewers.

Expanding the Agenda--Whither Research

Research conducted over the past 40 years leads to the inescapable conclusion that televised violence does affect viewers' attitudes, values and behavior (Hearold, 1986; Murray, 1994; Paik & Comstock, 1994). In general, there seem to be three main classes of effects--aggression, desensitization, and fearfulness:

- **Aggression:** Viewing televised violence can lead to increases in aggressive behavior and/or changes in attitudes and values favoring the use of aggression to solve conflicts;
- **Desensitization:** Extensive violence viewing may lead to decreased sensitivity to violence and a greater willingness to tolerate increasing levels of violence in society;
- **Fearfulness:** Extensive exposure to television violence may produce the "mean world syndrome" in which viewers overestimate their risk of victimization.

Although the body of research on the effects of viewing television violence is extensive and fairly coherent in demonstrating systematic patterns of influence, we know surprisingly little about the processes involved in the production of these effects. So too, we need to know more about the social factors that cause the high prevalence of TV violence, as well as factors that may reduce the prevalence of gratuitous violence in programming. Finally, we also require further research on efforts to intervene or remedy the harmful effects of violence viewing. Therefore, avenues for future research should include continuing analysis of the process, prevalence, and prevention of TV violence.

Process:

Although we know that viewing televised violence can lead to increases in aggressive behavior or fearfulness and changed attitudes and values about the role of violence in society, it would be helpful to know more about how these changes occur in viewers.

Within a social learning paradigm, we know that changes in behavior and thoughts can result from observing models in the world around us, be they parents, peers, or other role models, such as those provided by mass media. The processes involved in "modeling" or imitation and vicarious learning of overt behavior were addressed in social learning theories in the 1960's (Bandura, 1962; 1965; 1969; Berkowitz 1962; 1965) but we need to expand our understanding of the neurological processes that might govern the translation of the observed models into thoughts and actions.

As a start in this new direction, both Bandura (1994) and Berkowitz (1984) have provided have provided some theoretical foundations for the translation of communication "events" into thoughts and actions. Bandura's social-cognitive theory approach and Berkowitz's outline of a cognitive-neoassociation analysis posit a role for emotional arousal as an affective tag that may facilitate lasting influences. As Bandura (1994) notes: "People are easily aroused by the emotional expressions of others. Vicarious arousal operates mainly through an intervening self-arousal process....That is, seeing others react emotionally to instigating conditions activates emotion-arousing thoughts and imagery in observers." (p. 75). With regard to aggression, we know that viewing television violence can be emotionally arousing (e.g., Cline, Croft, & Courier, 1973; Osborn & Endsley, 1971; Zillman, 1971; 1982) but we lack direct measures of cortical arousal or activation patterns in relation to violence viewing.

The pursuit of neurological patterns of cortical arousal in violence viewing would likely start with the amygdala because it has a well-established role (LeDoux, 1996; LeDoux & Hirst, 1986) in the control of physiological responses to emotionally arousing or threatening stimuli. Indeed, a recent National Research Council (1993) report from the Panel on the Understanding and Control of Violent Behavior, concludes:

All human behavior, including aggression and violence, is the outcome of complex processes in the brain. Violent behaviors may result from relatively permanent conditions or from temporary states...Biological research on aggressive and violent behavior has given particular attention to the following in recent years: ... (2) functioning of steroid hormones such as testosterone and glucocorticoids, especially their action on steroid receptors in the brain; ... (6) neurophysiological (i.e., brain wave) abnormalities, particularly in the temporal lobe of the brain; (7) brain dysfunctions that interfere with language processing or cognition; (pp. 115-116).

Thus, one suggestion for further research on the impact of media violence is to assess some of the neurological correlates of viewing televised violence. In particular, the use of videotape violent scenes can serve as the ideal paradigm for assessing individual differences in responses to violence in society. However, before exploring individual differences, we need to conduct normative studies of neurological activation patterns related to violence. Figure 3 is an diagram of the brain sections of interest and Figure 4 is an MRI of a human brain section containing the amygdala.

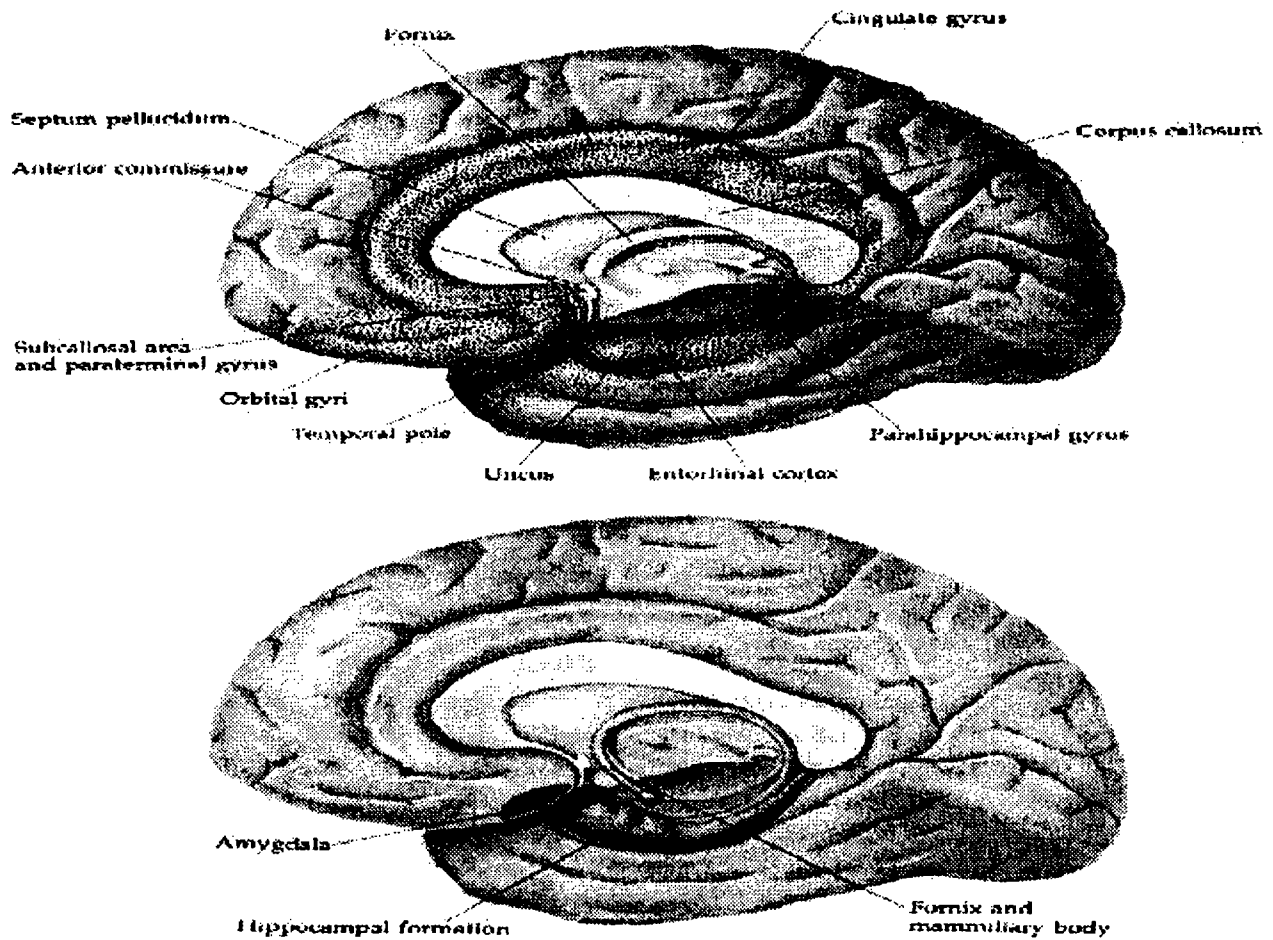


Figure 3: Location of the amygdala and surrounding cortical areas (Source: Martin, 1989).

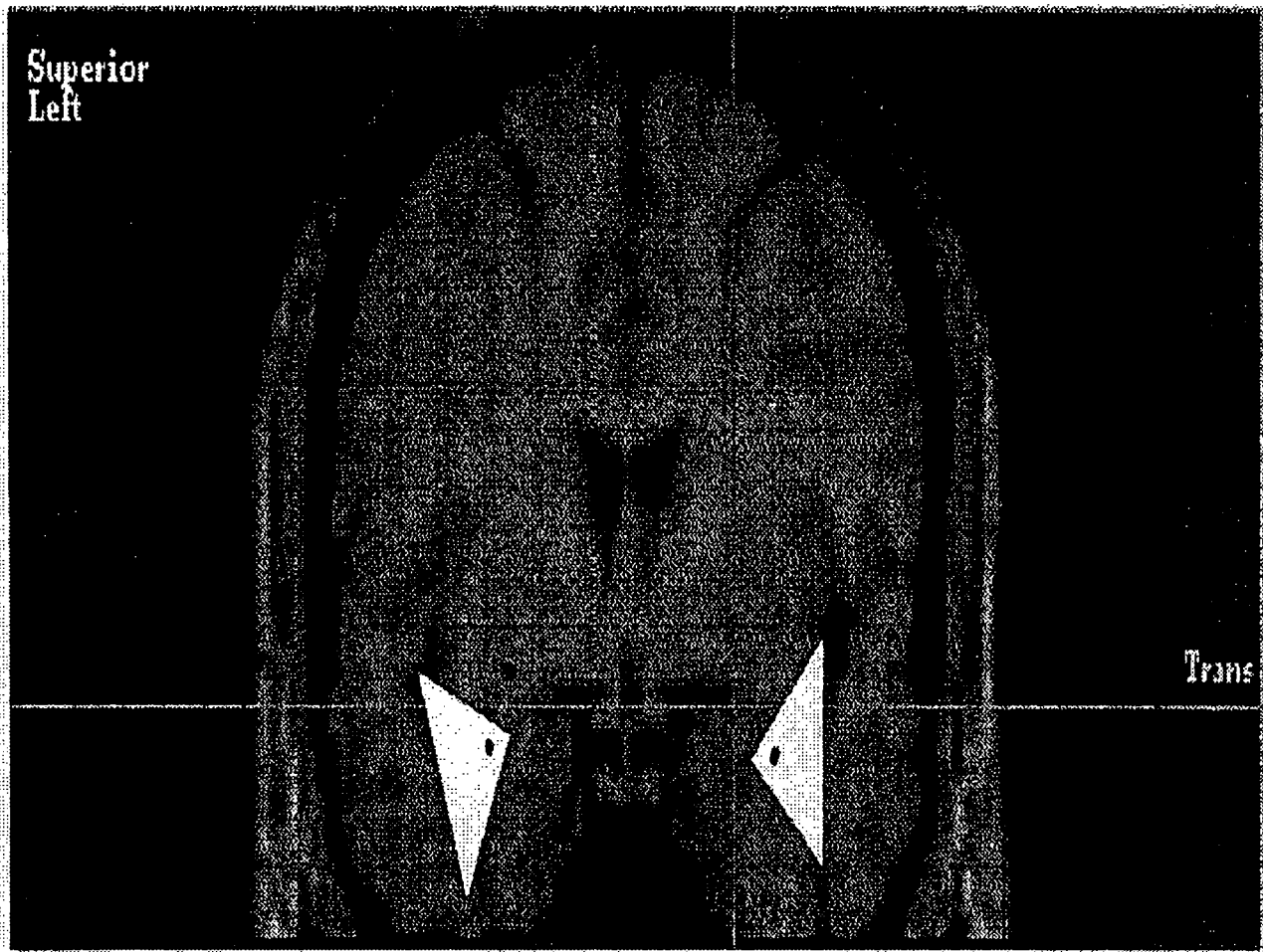


Figure 4: Magnetic Resonance Imaging scan showing location of the amygdala in the human brain (Source: Research Imaging Center, BrainMap, 1997).

It is very likely that the amygdala will be involved in processing violence but the projections to the cortex are not clear. However, developing hypotheses about violence viewing and brain activation would need to start with research on physiological arousal (e.g., Osborn & Endsley, 1971; Zillmann, 1982; Zillmann & Bryant, 1994) and link this to cortical arousal. In this regard, the work of Paul Ekman and Richard Davidson (Ekman, & Davidson, 1993; Ekman, Davidson, & Friesen, 1990; Davidson, Ekman, Saron, Senulis, & Friesen, 1990) using EEG recordings while subjects viewed gruesome films (a leg amputation) indicate asymmetries in activation patterns in the anterior regions of the left and right hemispheres. In particular, positive affect (indexed by facial expression) has been found to be associated with left-sided anterior activation, while negative affect is associated with right-sided activation (Davidson & Tomarken, 1989).

One proposal (Murray, 1997) to address questions about violence viewing and arousal, would conjoin measures of physiological arousal (e.g., GSR, heart rate) and social emotional responses (e.g., facial expressions of emotion) with neuroimaging techniques (e.g., functional Magnetic Resonance Imaging-fMRI--and Event Related Potential--ERP) to track the emotional and neurological processes involved in viewing televised violence. The question being explored in the San Antonio study is whether 8 to 12 year old children will display similar asymmetries in ERP recordings while watching televised violence or humor and whether fMRI activation patterns will be differentiated in ways that are consistent with facial expression and physiological measures of emotional arousal.

Whether, brain mapping (Toga & Maziotta, 1996) and other neuropsychological approaches prove to be fruitful remains to be seen but it is one avenue for building bridges between social learning theory concepts and the manifestation of aggressive behavior. And, such research might serve as a paradigm for more focused studies of individual differences in violence and aggression.

Prevalence:

A second direction for future research is a continuation of studies of the prevalence of violence in television programming. There is a long history of content analysis of television programming dating from the late 1960's (e.g., Gerbner, 1970) through the 1990's (e.g., Gerbner, Gross, & Morgan, 1994; Mediascope, 1996) and the results have been fairly consistent in demonstrating high levels of violence in televised entertainment and reality programs. However, it would be important to know more about the "social forces" that determine "outbreaks" of violence in entertainment media. What are the cultural and economic issues that support or encourage high levels of violence? We have seen, in Figure 1, that there have been "valleys of violence" at several points in the 30 years of monitoring TV violence that appear to be related to public outcry about high levels of media violence. However, what can we learn about the economic and social conditions that may be associated with the peaks or "mountains of violence" at various periods such as the early 1980's?

The continuation of prevalence studies will provide a tracking mechanism for monitoring changes in the media environment and it can inform broadcasters, public policymakers and researchers about the effectiveness of various interventions such as ratings systems or electronic screening devices. But, the most important reason for the continuation of prevalence studies is to assess the fairness of the representation of our culture in society's most pervasive communicator of culture (Berry, 1980; 1988; 1993). Thus, it is important to ask questions not only about the quantity of TV violence but also the quality of violence--the ways in which both victims and perpetrators are portrayed in violent programming. As Gerbner (1997) notes:

The important question to ask is Who is doing what to Whom?' because violence is essentially a demonstration of power. It shows who can get away with what against whom; who are the most likely winners and losers, perpetrators and victims. Violence-laden television tends to create an unfair pecking order' with women, children, older people, and minorities at the bottom. (p. 2).

In this regard, Gerbner proposes the recasting of his long-established Violence Index (cf., Gerbner, et al., 1994) into a Fairness Index (Gerbner, 1997) that would assess the extent to which media portrayals provide a "fair demographic representation" of various social groups in proportion to their representation in the actual population. As one example, he is conducting an analysis, for the Screen Actors Guild, of the fairness of representation in 1995-96 prime time television drama with representation in the 1994-95 commercially most successful films. These forms of prevalence studies provide insights into the culture of television violence and the ways in which one might fashion intervention programs to prevent harmful effects.

Prevention:

The final area for much-needed research is the task of developing and assessing intervention strategies that will prevent or mitigate the influences of media violence. This prevention issue is a topic of intense recent interest (e.g., American Psychological Association, 1993; Eron, Gentry, & Schlegel, 1994; National Research Council, 1993; Prothrow-Stith, 1991) but remains the most difficult area for research

and development.

There are several organizations that have developed discussion and instruction materials for use in schools and community organizations (e.g., Center for Media Literacy, 1995; Kunkel & Murray, 1991; Levin & Gerzon, 1996; Mediascope, 1993; Mind Science Foundation, 1997; Murray & Lonnborg, 1995) but there needs to be a more integrated approach to program development and a systematic evaluation of the effectiveness of these interventions. All of these programs are designed to raise awareness, in children or adults, of the ways in which TV violence influences the viewer and all attempt to teach "critical viewing" skills. At present, the most elaborate and comprehensive program in this genre is the video and community discussion kit, *Beyond blame: Challenging violence in the media--a multimedia literacy program for community empowerment*, developed by the Center for Media Literacy (1995). Nevertheless, it remains for a new generation of researchers and clinicians to establish new paradigms for effective intervention and prevention.

Continuing Needs:

The future holds the promise of a greater collaboration between the television industry, government and professional and community organizations devoted to the task of reducing violence in media and society.

History provides examples of effective voluntary industry response to concern about television violence through the development of alternative educational and entertaining programming such as *Fat Albert* and the *Cosby Kids* (e.g., Columbia Broadcasting System, 1977) or *School House Rock* (American Broadcasting Companies, Inc., 1978), as well as the extensive programming of public television (Children's Television Workshop, 1990; Palmer, 1988).

Finally, the collaborative efforts of Congress and the Federal Communications Commission (Hundt, 1994; 1996) in the passage of the Children's Television Act of 1990 and regulations concerning the establishment of electronic screening devices (e.g., the V-Chip), ensure continuing emphasis on the need to address the levels of violence in television programming. So too, the institution of ratings systems (e.g., Federman, 1993; OKTV Foundation, 1995; Wilson, Linz, & Randall, 1990) and the development of guidelines for the portrayal of violence (Livingston, 1994) suggest that both parents and the television industry will have clearer views of nature of television violence. As we move into the next century, process, prevalence, and prevention will serve as the central organizing themes for studies of television violence.

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Advocacy & Communications

VIRTUAL VIOLENCE

SUBJECT INCLUDES: Gang/Juvenile Violence
Video Games and Cyberspace Violence
Music Violence

GRADE: D+

SUMMARY OF STATUS: The grade for virtual violence is up from a D last year because of heightened public awareness and an apparent commitment on the part of government and industry to address the problem. The enactment of legislation has promised the V-Chip and a new television rating system. Rating systems are also being developed for the music and cyberspace industries. Significant new studies of violence on television have increased our understanding of the important role context plays in how violence is perceived and will provide valuable tools for those who wish to produce responsible programming in the future. A number of consumer and industry groups have put together new guidelines to help parents monitor and evaluate their children's entertainment choices.

However, scientific studies have conclusively established that exposure to violence in entertainment media increases aggressive behavior, is associated with lower levels of pro-social behavior, and contributes to Americans' sense that they live in a "mean society." There is no evidence that virtual violence is on the decline -- yet. Violence is still rampant in all forms of entertainment media, and consumers are still buying it.

Television Violence

When the AMA issued its Report Card on Violence in June of last year, it proposed several intervention strategies to help stem the tide of virtual violence, including implementation of a V-Chip to allow parents to block objectionable television programming and development of an industry-wide television rating system similar to that used by the motion picture industry. Both measures are part of the new telecommunications law, enacted in February 1996.

For the first time, two important industry studies have analyzed the context in which television violence is presented. The National Television Violence Study found that context and explicitness of portrayals of violence are just as important as the quantity of violence portrayed. The study identifies and surveys such contextual factors as the nature of perpetrators and victims, what consequences are shown, the involvement of humor, and whether or not the violent act is condoned or condemned.

The study also uncovered important information about the effectiveness of rating systems and advisories that should prove helpful in devising a meaningful and effective television rating system. An earlier study by the UCLA Center for Communications Policy also evaluated televised violence in a contextual manner. That study identified continuing problems with the broadcast of films on television and with children's programming where sinister combat violence shows are increasingly dominate.

Serious concerns have also been raised about the consistency and effectiveness of the movie rating system on which the new television rating system will be based. The motion picture industry's ratings are determined by a board of concerned parents, none of whom have training in child development or the effect of mass media on children. The rating system ignores critical child development stages and focuses on how parents feel about a film rather than on how it might affect children. There are problems with consistency of ratings and no evaluation of the context in which violence occurs. Unless these

problems are resolved, the television ratings system could prove as ineffective and unreliable as that of the motion picture industry.

Video Game and Cyberspace Violence

The Internet, a global "network of networks" is not governed by any government or private entity. This vacuum leaves no checks or limits on the information maintained by and accessible to users and holds no one accountable when superhighway accidents occur.

Evidence of violence on the Internet is anecdotal, rather than statistical, in part because communication on the Internet is private. Reported cases of abuse are relatively infrequent, but as the technology continues to explode, there is potential for great harm, as well as great good.

All of the online services offer parental control devices which screen online content for certain key words, phrases or names and then block or restrict access to the content parents identify as objectionable. Other blocking devices allow parents to block entire areas such as chat rooms and electronic bulletin boards, and to monitor their child's access. Parental control devices are also available for users who want to access the Internet directly, instead of going through an online service.

As with all parental control devices, blocking mechanisms are not effective in protecting children unless parents have the knowledge and interest to use them wisely. Unfortunately, the children most at risk on the Internet are the very children whose parents have abdicated responsibility. No control device exists to protect those children from harm.

Internet violence may be the most troubling of all forms of virtual violence because the Internet provides a global audience. Last year, the Oklahoma bombing suspect obtained a copy of the "Turner Diaries" from the Internet. Whereas before, one would have had to know where to look and been pre-disposed to search for the book, the Internet made it easily accessible to a broad audience. It is that potential to exponentially increase the public's exposure to violent images and violent thoughts which causes the deepest concern and most eludes quick solutions.

The impact of violent video games upon children is not as clearly established as the impact of violent television programming. Due to their role-modeling capacity to promote real-world violence, there is concern that playing violent video games with their fully digitalized human images will cause children to become more aggressive towards other children and become more tolerant of, and more likely to engage in, real-life violence.

The video game industry recognizes that all games are not appropriate for all age groups and voluntarily rated more than 2,000 videos last year. The rating system consists of both age-based classifications and an explanation of the reasons for the rating. The Video Software Dealers Association has implemented a "Pledge to Parents" program to enforce the ratings system adhered to by the Blockbuster video chain, Toys R Us and Wal-Mart, among others.

Music Violence

Public pressure continues to have an impact on the music industry. In 1985, the Parents Music Resource Center succeeded in pressuring the record industry to attach the "Parental Advisory, Explicit Lyrics" warning labels that many companies now voluntarily place on selected records. In 1995, public pressure from advocacy groups played a role in forcing Warner Music Group to sever its 50 percent stake in Interscope Records, home to Nine Inch Nails and controversial rap artists Snoop Doggy Dogg and Dr. Dre.

However, Time Warner's actions did not stop the flood of "gangsta" rap. Rap artists simply turned to a different distribution network and when the CDs hit the stores, lyrics which glorified guns, rape, and murder were left intact. Efforts are once again underway to help parents evaluate the content of their children's music. Imposition of a mandatory rating system for music, however, has gained little public or

legislative support.

Conclusion

Over the next year the AMA will be tracking to see if the promising new intervention programs noted in this report are successfully implemented by government and industry. New tools like music labels, the V-Chip and voluntary rating system offer hope of reducing virtual violence. But for now, this violence is still a problem for all of us and new tools will only be as strong and successful as the public's commitment to using them. The AMA especially encourages American parents to get involved and use these tools diligently to monitor not only their own, but also their children's exposure to virtual violence.

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Television and Violence

The Scale of the Problem and Where to Go From Here

Brandon S. Centerwall, MD, MPH

IN 1975, Rothenberg's Special Communication in *JAMA*, "Effect of Television Violence on Children and Youth," first alerted the medical community to the deforming effects the viewing of television violence has on normal child development, increasing levels of physical aggressiveness and violence.¹ In response to physicians' concerns sparked by Rothenberg's communication, the 1976 American Medical Association (AMA) House of Delegates passed Resolution 38: "The House declares TV violence threatens the health and welfare of young Americans, commits itself to remedial actions with interested parties, and encourages opposition to TV programs containing violence and to their sponsors."²

Other professional organizations have since come to a similar conclusion, including the American Academy of Pediatrics and the American Psychological Association.³ In light of recent research findings, in 1990 the American Academy of Pediatrics issued a policy statement: "Pediatricians should advise parents to limit their children's television viewing to 1 to 2 hours per day."⁴

Rothenberg's communication was largely based on the findings of the 1968 National Commission on the Causes and Prevention of Violence⁵ and the 1972 Surgeon General's report, *Television and Growing Up: The Impact of Televised Violence*.⁶ Those findings were updated and reinforced by the 1982 report of the National Institute of Mental Health, *Television and Behavior: Ten Years of Scientific Progress and Impli-*

cations for the Eighties, again documenting a broad consensus in the scientific literature that exposure to television violence increases children's physical aggressiveness.⁷ Each of these governmental inquiries necessarily left open the question of whether this increase in children's physical aggressiveness would later lead to increased rates of violence. Although there had been dozens of laboratory investigations and short-term field studies (3 months or less), few long-term field studies (2 years or more) had been completed and reported. Since the 1982 National Institute of Mental Health report, long-term field studies have come into their own, some 20 having now been published.⁸

In my commentary, I discuss television's effects within the context of normal child development; give an overview of natural exposure to television as a cause of aggression and violence; summarize my own research findings on television as a cause of violence; and suggest a course of action.

TELEVISION IN THE CONTEXT OF NORMAL CHILD DEVELOPMENT

The impact of television on children is best understood within the context of normal child development. Neonates are born with an instinctive capacity and desire to imitate adult human behavior. That infants can, and do, imitate an array of adult facial expressions has been demonstrated in neonates as young as a few hours old, ie, before they are even old enough to know cognitively that they themselves have facial features that correspond with those they are observing.^{9,10} It is a most useful instinct, for the developing child must learn and master a vast repertoire of behavior in short order.

Whereas infants have an instinctive desire to imitate observed human behavior, they do not possess an instinct for gauging a priori whether a behavior ought to be imitated. They will imitate anything,¹¹ including behaviors that most adults would regard as destructive and antisocial. It may give pause for thought, then, to learn that infants as young as 14 months of age demonstrably observe and incorporate behaviors seen on television (Fig 1).^{12,13} (Looking ahead, in two surveys of young male felons imprisoned for committing violent crimes, eg, homicide, rape, and assault, 22% to 34% reported having consciously imitated crime techniques learned from television programs, usually successfully.¹⁴)

As of 1990, the average American child aged 2 to 5 years was watching over 27 hours of television per week.¹⁵ This might not be bad, if young children understood what they are watching. However, up through ages 3 and 4 years, many children are unable to distinguish fact from fantasy in television programs and remain unable to do so despite adult coaching.¹⁶ In the minds of such young children, television is a source of entirely factual information regarding how the world works. Naturally, as they get older, they come to know better, but the earliest and deepest impressions were laid down when the child saw television as a factual source of information about a world outside their homes where violence is a daily commonplace and the commission of violence is generally powerful, exciting, charismatic, and efficacious. Serious violence is most likely to erupt at moments of severe stress—and it is precisely at such moments that adolescents and adults are most likely to revert to their earliest, most visceral

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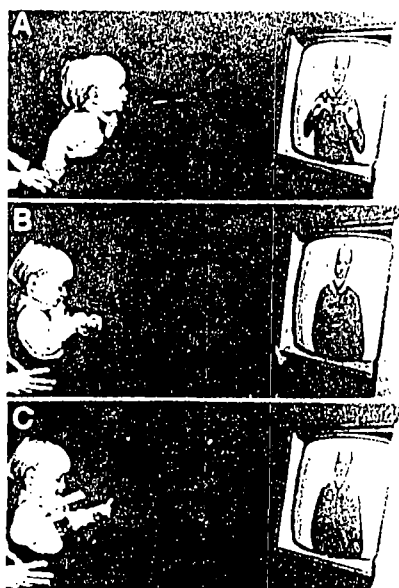


Fig 1.—This series of photographs shows a 14-month-old boy learning behavior from a television set. In photograph A the adult pulls apart a novel toy. The infant leans forward and carefully studies the adult's actions. In photograph B the infant is given the toy. In photograph C the infant pulls the toy apart, imitating what he had seen the adult do. Of infants exposed to the instructional video, 65% could later work the toy, as compared with 20% of unexposed infants ($P<.001$) (reprinted with permission from Meltzoff¹⁷).

sense of what violence is and what its role is in society. Much of this sense will have come from television.

Not all laboratory experiments and short-term field studies demonstrate an effect of media violence on children's behavior, but most do.^{17,18} In a recent meta-analysis of randomized, case-control, short-term studies, exposure to media violence caused, on the average, a significant increase in children's aggressiveness as measured by observation of their spontaneous, natural behavior following exposure ($P<.05$).¹⁹

NATURAL EXPOSURE TO TELEVISION AS A CAUSE OF AGGRESSION AND VIOLENCE

In 1973, a small Canadian town (called "Notel" by the investigators) acquired television for the first time. The acquisition of television at such a late date was due to problems with signal reception rather than any hostility toward television. Joy et al²⁰ investigated the impact of television on this virgin community, using as control groups two similar communities that already had television. In a double-blind research design, a cohort of 45 first- and second-grade students were observed prospectively over a period of 2 years for rates of objectively measured noxious physical aggression (eg, hitting, shov-

ing, and biting). Rates of physical aggression did not change significantly among children in the two control communities. Two years after the introduction of television, rates of physical aggression among children in Notel had increased by 160% ($P<.001$).

In a 22-year prospective study of an age cohort in a semirural US county ($N=875$), Huesmann²¹ observed whether boys' television viewing at age 8 years predicted the seriousness of criminal acts committed by age 30. After controlling for the boys' baseline aggressiveness, intelligence, and socioeconomic status at age 8, it was found that the boys' television violence viewing at age 8 significantly predicted the seriousness of the crimes for which they were convicted by age 30 ($P<.05$).

In a retrospective case-control study, Kruttschnitt et al²² compared 100 male felons imprisoned for violent crimes (eg, homicide, rape, and assault) with 65 men without a history of violent offenses, matching for age, race, and census tract of residence at age 10 to 14 years. After controlling for school performance, exposure to parental violence, and baseline level of criminality, it was found that the association between adult criminal violence and childhood exposure to television violence approached statistical significance ($P<.10$).

All Canadian and US studies of the effect of prolonged childhood exposure to television (2 years or more) demonstrate a positive relationship between earlier exposure to television and later physical aggressiveness, although not all studies reach statistical significance.⁸ The critical period of exposure to television is preadolescent childhood. Later variations in exposure, in adolescence and adulthood, do not exert any additional effect.^{23,24} However, the aggression-enhancing effect of exposure to television is chronic, extending into later adolescence and adulthood.^{8,25} This implies that any interventions should be designed for children and their caregivers rather than for the general adult population.

These studies confirm what many Americans already believe on the basis of intuition. In a national opinion poll, 43% of adult Americans affirm that television violence "plays a part in making America a violent society," and an additional 37% find the thesis at least plausible (only 16% frankly disbelieve the proposition).²⁶ But how big a role does it play? What is the effect of natural exposure to television on entire populations? To address this issue, I took advantage of an historical experiment—the absence of television in South Africa prior to 1975.²⁷

TELEVISION AND HOMICIDE IN SOUTH AFRICA, CANADA, AND THE UNITED STATES

The South African government did not permit television broadcasting prior to 1975, even though South African whites were a prosperous, industrialized Western society.⁸ Amidst the hostile tensions between the Afrikaner and English white communities, it was generally conceded that any South African television broadcasting industry would have to rely on British and American imports to fill out its programming schedule. Afrikaner leaders felt that that would provide an unacceptable cultural advantage to the English-speaking white South Africans. Rather than negotiate a complicated compromise, the Afrikaner-controlled government chose to finesse the issue by forbidding television broadcasting entirely. Thus, an entire population of 2 million whites—rich and poor, urban and rural, educated and uneducated—was nonselectively and absolutely excluded from exposure to television for a quarter century after the medium was introduced into the United States. Since the ban on television was not based on any concerns regarding television and violence, there was no self-selection bias with respect to the hypothesis being tested.

To evaluate whether exposure to television is a cause of violence, I examined homicide rates in South Africa, Canada, and the United States. Given that blacks in South Africa live under quite different conditions than blacks in the United States, I limited the comparison to white homicide rates in South Africa and the United States and the total homicide rate in Canada (which was 97% white in 1951). Data analyzed were from the respective government vital statistics registries. The reliability of the homicide data is discussed elsewhere.⁸

Following the introduction of television into the United States, the annual white homicide rate increased by 93%, from 3.0 homicides per 100 000 white population in 1945 to 5.8 per 100 000 in 1974; in South Africa, where television was banned, the white homicide rate decreased by 7%, from 2.7 homicides per 100 000 white population in 1943 through 1948 to 2.5 per 100 000 in 1974 (Fig 2). As with US whites, following the introduction of television into Canada the Canadian homicide rate increased by 92%, from 1.3 homicides per 100 000 population in 1945 to 2.5 per 100 000 in 1974 (Fig 3).

For both Canada and the United States, there was a lag of 10 to 15 years between the introduction of television and the subsequent doubling of the ho-

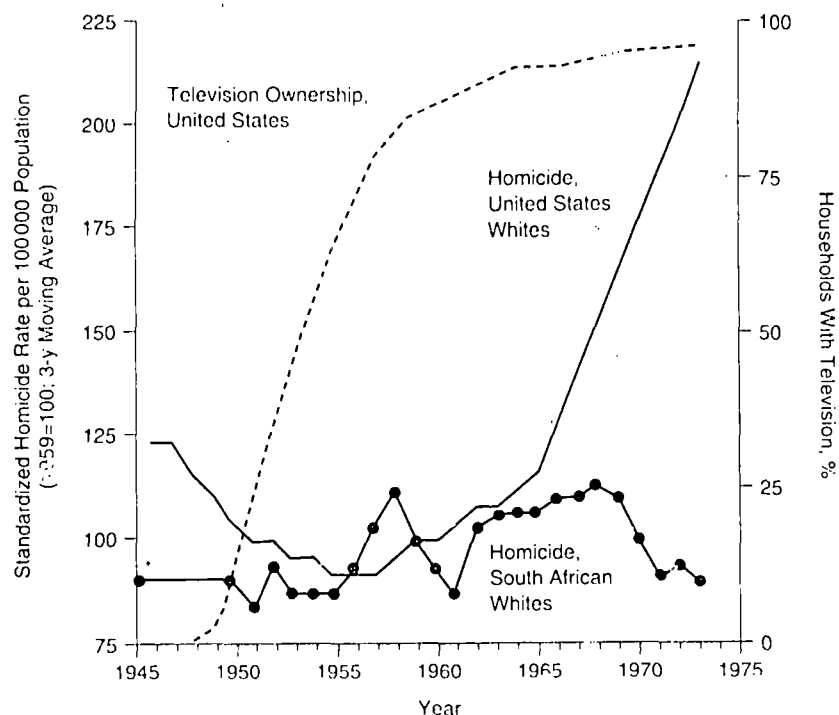


Fig 2.—Television ownership and white homicide rates, United States and South Africa, 1945 through 1975. Asterisk denotes 6-year average. Note that television broadcasting was not permitted in South Africa prior to 1975 (from Centerwall¹⁸ and reprinted by permission of Academic Press).

micide rate (Figs 2 and 3). Given that homicide is primarily an adult activity, if television exerts its behavior-modifying effects primarily on children, the initial "television generation" would have had to age 10 to 15 years before they would have been old enough to affect the homicide rate. If this were so, it would be expected that, as the initial television generation grew up, rates of serious violence would first begin to rise among children, then several years later it would begin to rise among adolescents, then still later among young adults, and so on. And that is what is observed.²

In the period immediately preceding the introduction of television into Canada and the United States, all three countries were multiparty, representative, federal democracies with strong Christian religious influences, where people of nonwhite races were generally excluded from political power. Although television broadcasting was prohibited prior to 1975, white South Africa had well-developed book, newspaper, radio, and cinema industries. Therefore, the effect of television could be isolated from that of other media influences. In addition, I examined an array of possible confounding variables—changes in age distribution, urbanization, economic con-

ditions, alcohol consumption, capital punishment, civil unrest, and the availability of firearms.² None provided a viable alternative explanation for the observed homicide trends. For further details regarding the testing of the hypothesis, I refer the reader to the published monograph¹⁸ and commentary.²⁰

A comparison of South Africa with only the United States (Fig 2) could easily lead to the hypothesis that US involvement in the Vietnam War or the turbulence of the civil rights movement was responsible for the doubling of homicide rates in the United States. The inclusion of Canada as a control group precludes these hypotheses, since Canadians likewise experienced a doubling of homicide rates (Fig 3) without involvement in the Vietnam War and without the turbulence of the US civil rights movement.

When I published my original paper in 1989, I predicted that white South African homicide rates would double within 10 to 15 years after the introduction of television in 1975, the rate having already increased 56% by 1983 (the most recent year then available).² As of 1987, the white South African homicide rate had reached 5.8 homicides per 100,000 white population, a 130% increase in the homicide rate from the

rate of 2.5 per 100,000 in 1974, the last year before television was introduced.²⁷ In contrast, Canadian and white US homicide rates have not increased since 1974. As of 1987, the Canadian homicide rate was 2.2 per 100,000, as compared with 2.5 per 100,000 in 1974.²⁸ In 1987, the US white homicide rate was 5.4 per 100,000, as compared with 5.8 per 100,000 in 1974.²⁹ (Since Canada and the United States became saturated with television by the early 1960s [Figs 2 and 3], it was expected that the effect of television on rates of violence would likewise reach a saturation point 10 to 15 years later.)

It is concluded that the introduction of television in the 1950s caused a subsequent doubling of the homicide rate, ie, long-term childhood exposure to television is a causal factor behind approximately one half of the homicides committed in the United States, or approximately 10,000 homicides annually. Although the data are not as well developed for other forms of violence, they indicate that exposure to television is also a causal factor behind a major proportion—perhaps one half—of rapes, assaults, and other forms of interpersonal violence in the United States.² When the same analytic approach was taken to investigate the relationship between television and suicide,²⁰ it was determined that the introduction of television in the 1950s exerted no significant effect on subsequent suicide rates.²⁰

To say that childhood exposure to television and television violence is a predisposing factor behind half of violent acts is not to discount the importance of other factors. Manifestly, every violent act is the result of an array of forces coming together—poverty, crime, alcohol and drug abuse, stress—of which childhood exposure to television is just one. Nevertheless, the epidemiologic evidence indicates that if, hypothetically, television technology had never been developed, there would today be 10,000 fewer homicides each year in the United States, 70,000 fewer rapes, and 700,000 fewer injurious assaults.^{25,31}

WHERE TO GO FROM HERE

In the war against tobacco, the tobacco industry is the last group from whom we expect any meaningful action. If someone were to call on the tobacco industry to cut back tobacco production as a matter of social conscience and out of concern for the public health, we would regard that person as being at least simple-minded, if not frankly deranged. Oddly enough, however, people have persistently assumed that the television industry operates by a higher standard of morality than the tobacco industry—that it is useful to appeal to its social

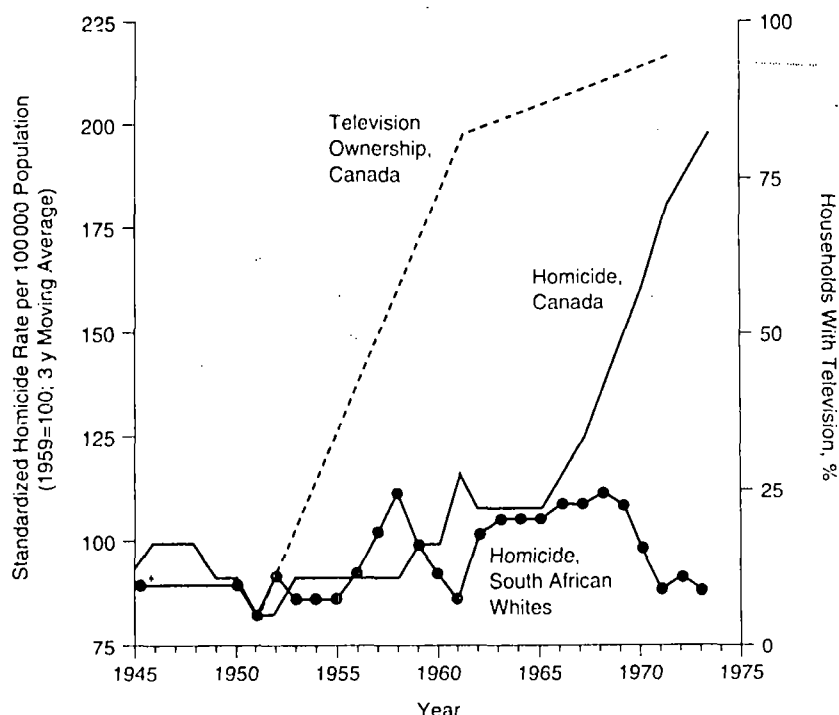


Fig 3.—Television ownership and homicide rates, Canadians and white South Africans, 1945 through 1973. Asterisk denotes 6-year average. Note that television broadcasting was not permitted in South Africa prior to 1975 (from Centerwall¹⁸ and reprinted by permission of Academic Press).

conscience. This was true in 1969 when the National Commission on the Causes and Prevention of Violence published its recommendations for the television industry.³² It was equally true in 1989 when the US Congress passed a television anti-violence bill that granted television industry executives the authority to confer on the issue of television violence without being in violation of antitrust laws.³³ Even before the law was fully passed, the four networks stated that they had no intention of using this antitrust exemption to any useful end and that there would be no substantive changes in programming content.³⁴ They have been as good as their word.

Cable aside, the television industry is not in the business of selling programs to audiences. It is in the business of selling audiences to advertisers. Issues of "quality" and "social responsibility" are entirely peripheral to the issue of maximizing audience size within a competitive market—and there is no formula more tried and true than violence for reliably generating large audiences that can be sold to advertisers. If public demand for tobacco decreases by 1%, the tobacco industry will lose \$250 million annually in revenue.³⁵ Similarly, if the television audience size were to de-

crease by 1%, the television industry would stand to lose \$250 million annually in advertising revenue.³⁵ Thus, changes in audience size that appear trivial to you and me are regarded as catastrophic by the industry. For this reason, industry spokespersons have made innumerable protestations of good intent, but nothing has happened. In over 20 years of monitoring levels of television violence, there has been no downward movement.^{36,37} There are no recommendations to make to the television industry. To make any would not only be futile but create the false impression that the industry might actually do something constructive.

The American Academy of Pediatrics recommends that pediatricians advise parents to limit their children's television viewing to 1 to 2 hours per day.¹ This is an excellent point of departure and need not be limited to pediatricians. It may seem remote that a child watching television today can be involved years later in violence. A juvenile taking up cigarettes is also remote from the dangers of chronic smoking, yet those dangers are real, and it is best to intervene early. The same holds true regarding television-viewing behavior. The instruction is simple: For children, less TV is better, especially violent TV.

Symbolic gestures are important, too. The many thousands of physicians who gave up smoking were important role models for the general public. Just as many waiting rooms now have a sign saying, "This Is a Smoke-Free Area" (or words to that effect), so likewise a sign can be posted saying, "This Is a Television-Free Area." (This is not meant to exclude the use of instructional videotapes.) By sparking inquiries from parents and children, such a simple device provides a low-key way to bring up the subject in a clinical setting.

Children's exposure to television and television violence should become part of the public health agenda, along with safety seats, bicycle helmets, immunizations, and good nutrition. One-time campaigns are of little value. It needs to become part of the standard package: Less TV is better, especially violent TV. Part of the public health approach should be to promote child-care alternatives to the electronic baby-sitter, especially among the poor who cannot afford real baby-sitters.

Parents should guide what their children watch on television and how much. This is an old recommendation³⁸ that can be given new teeth with the help of modern technology. It is now feasible to fit a television set with an electronic lock that permits parents to preset which programs, channels, and times they wish the set to be available for; if a particular program or time of day is locked, the set won't turn on for that time or channel.³⁸ The presence of a time-channel lock restores and reinforces parental authority, since it operates even when the parents are not at home, thus permitting parents to use television to their family's best advantage. Time-channel locks are not merely feasible, but have already been designed and are coming off the assembly line (eg, the Sony XBR).

Closed captioning permits deaf and hard-of-hearing persons access to television. Recognizing that market forces alone would not make closed-captioning technology available to more than a fraction of the deaf and hard-of-hearing, the Television Decoder Circuitry Act was signed into law in 1990, requiring that, as of 1993, all new television sets (with screens 33 cm or larger, ie, 96% of new television sets) be manufactured with built-in closed-captioning circuitry.³⁹ A similar law should require that eventually all new television sets be manufactured with built-in time-channel lock circuitry—and for a similar reason. Market forces alone will not make this technology available to more than a fraction of households with children and will exclude poor families, the ones who suffer the most from violence. If we can make

television technology available that will benefit 24 million deaf and hard-of-hearing Americans,³⁹ surely we can do no less for the benefit of 50 million American children.⁴⁰

Unless they are provided with information, parents are ill-equipped to judge which programs to place off-limits. As a final recommendation, television programs should be accompanied by a violence rating so parents can gauge how violent a program is without having to watch it. Such a rating system should be

quantitative and preferably numerical, leaving aesthetic and social judgments to the viewers. Exactly how the scale ought to be quantified is less important than that it be applied consistently. Such a rating system would enjoy broad popular support: In a national poll, 71% of adult Americans favor the establishment of a violence rating system for television programs.⁴¹

It should be noted that none of these recommendations impinges on issues of freedom of speech. That is as it should

be. It is not reasonable to address the problem of motor vehicle fatalities by calling for a ban on cars. Instead, we emphasize safety seats, good traffic signs, and driver education. Similarly, to address the problem of violence caused by exposure to television, we need to emphasize time-channel locks, program rating systems, and education of the public regarding good viewing habits.

Figure 1 was provided by A. N. Meltzoff, University of Washington, Seattle.

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Advocacy & Communications

Facts about virtual violence

Violence in Entertainment

TELEVISION AND MOVIE VIOLENCE

"Heavy viewers of TV violence suffer from a 'Mean World Syndrome' and that has all kinds of consequences. They are more likely to overestimate their chances of encountering violence, to believe that their neighborhoods are unsafe and to assume that crime is rising, whether or not it actually is. They are also more likely to buy guns for protection. People are almost paralyzed with fear."

**George Gerber, Ph.D. Dean, Emeritus
Annenberg School of Communications
University of Pennsylvania**

"The risks of viewing the most common depictions of televised violence include learning to behave violently, becoming more desensitized to the harmful consequences of violence and becoming more fearful of being attacked."

National Television Violence Study

"We see positive signs that some important issues of television violence -- particularly in series and television movies -- are being addressed. But at the same time, important problems still remain and need to be confronted."

**Jeffrey Cole, Ph.D.
Director, UCLA Center for Communications Policy**

Statistics

- By the time the average American child finishes elementary school, he or she has typically witnessed 8,000 murders and 100,000 acts of violence on television. (1)
- By the time that child reaches age 18, the number of violent television acts he or she has been exposed to increases to 200,000, including 40,000 acts of murder. (2)
- Longitudinal studies which track viewing habits and behavior patterns of a single individual over time found that 8-year-old boys who viewed the most violent programs growing up were the most likely to engage in aggressive and delinquent behavior by age 18 and serious criminal behavior by age 30. (3)
- Television violence affects youngsters of all ages, both genders, all socioeconomic levels and all levels of intelligence. The effect is not limited to children predisposed to aggressive behavior. Instead, television violence creates a vicious cycle in which televised violence causes children to become more aggressive, and these more aggressive children in turn, watch more violence on television to justify their own behavior. (4)
- Ninety-nine percent of American households have at least one television set. Sixty-six percent of American children live in households with three or more television sets. (5)
- Fifty-four percent of children questioned had a television set in their own bedroom and 55% usually watched television alone or with a friend, but not with their families. (5)
- A USA Today poll conducted in early June 1995 found that 97% of Americans were concerned

- about television violence. (6)
- Polls show further that three-quarters of the public finds television entertainment too violent. When asked to select measures which would reduce violent crime "a lot," Americans chose restrictions on TV violence more frequently than gun control. (7)
- According to the "National Television Violence Study, a ground-breaking, three-year study financed by the cable industry, the majority of television programs (57%) contained some violent content. (8)
- The National Television Violence Study analyzed the context in which violence was depicted and found that perpetrators of violent acts on television go unpunished 73% of the time. Bad characters are punished 62% of the time -- good characters only 15% of the time. Forty-seven percent of all violent interactions showed no resulting harm to the victims, and 58% depicted no pain. Longer-term consequences, such as financial or emotional harm were shown only 16% of the time. (9)
- Twenty-five percent of violent acts on television involve the use of a handgun. Only 4% of programs containing violence emphasized non-violent alternatives to solving problems. (10)
- Forty-six percent of all TV violence identified by the study took place in children's cartoons. Children's programs posed special concerns because they were least likely to depict the long-term consequences of violence (5%) and they portray violence in a humorous fashion 67% of the time. (11)
- The use of parental warnings and violence advisories made the programs more of a magnet than they might otherwise have been. Parental Discretion Advised and PG-13 and R ratings significantly increased boys' interest in the shows, although they made girls less interested in watching. (12)
- There is no evidence that public service announcements or other anti-violence programs significantly alter adolescents' attitudes toward the appropriateness of using violence to resolve conflicts. The anti-violence messages of many public service announcements are often undercut by the use of celebrity endorsers who are perceived as promoting violence in their real life jobs. (13)
- The most serious source of concern regarding television violence occurs in network broadcast of theatrical films, particularly action films with as many as 40 scenes of violence. Of the 118 theatrical films monitored, 50 (or 42%) raised concerns about their use of violence. (14)
- Inspired by movies such as *The Jungle Book*, *Three Ninjas*, and *Dumb and Dumber*, researchers found in a nationwide survey of 2,000 boys and girls, that 9.1% of boys and 2.2% of girls reported being victims of genital assault in 1995. Kids reported that an assailant tried or actually succeeded in kicking their genitals (43%), followed by being hit (36%) and being hit with an object (8%). One in every 50 incidents required medical attention. (15)

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VIDEO GAMES AND CYBERSPACE VIOLENCE

"The best way to assure that your children are having positive online experiences is to stay in touch with what they're doing."

National Center for Missing & Exploited Children

"The best weapon against possible online abuses is an informed and empowered community of users. Likewise, the best way to protect children from inappropriate material is to empower parents, schools, and other organizations with information on how they can effectively control and monitor children's access."

Interactive Services Association

"It's not just naked women. Perhaps because hard-core sex pictures are so widely available elsewhere, the adult BBS market (electronic bulletin board market) seems to be driven largely by a demand for images that can't be found in the average magazine."

**Time Magazine
July 3, 1995**

Statistics

- The Internet, a global "network of networks" is not governed by any government or private entity. This vacuum leaves no checks or limits on the information maintained by and accessible to users. No single person or entity owns the Internet, leaving no one accountable for the accidents which occur on its highways. (1)
- The incidence of violence on the Internet is difficult to quantify because the technology has moved faster than our capability to monitor it. Evidence of violence on the Internet is anecdotal, rather than statistical, in part because communication on the Internet is private. Reported cases of abuse are relatively infrequent, but as the technology continues to explode, there is potential for great harm as well as great good. (2)
- The Internet could become a stalking ground for child molesters who have moved from the playground to the Internet attracted by the anonymity it offers. The National Center for Missing and Exploited Children has documented more than a dozen cases in the last year of cyberspace seduction by pedophiles in which children were lured by on-line predators into traveling to

- locations hundreds of miles from their homes where they were then sexually assaulted. (3)
- The Oklahoma bombing suspect obtained a copy of the "Turner Diaries," a book which advocates the violent overthrow of government, off the Internet. Whereas before, one would have had to know exactly where to look and be pre-disposed to search for the book, the Internet made it easily accessible to a global audience. (4)
- The impact of violent video games upon children is not as clearly established as the impact of violent television programming. Young children possess an instinctive desire to imitate actions which they observe, without always possessing the intellect or maturity to determine if such actions are appropriate. Due to their role-modeling capacity to promote real world violence, there is deep concern that playing violent video games, with their fully digitalized human images, will cause children to become more aggressive towards other children and become more tolerant of, and more likely to engage in, real-life violence. (5)

NOTES:

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MUSIC VIOLENCE

"It's not necessarily important to censor a child's exposure to entertainment, but you should be aware that millions of dollars are spent targeting your child to buy a certain record. I've sat in meetings where the record label executives lament the fact that a record isn't controversial enough."

Charlie Gilreath
Entertainment Monitor

"I don't think for a minute that gangsta rap will go away. A foreign company will pick it up. We still must find a way to let parents know what's out there."

Barbara Wyatt
Parents Music Resource Center

Statistics

- The Parents Music Resource Center reports that American teenagers listen to an estimated 10,500 hours of rock music between the 7th and 12th grades alone - just 500 hours less than they spend in school over twelve years. (1)
- Entertainment Monitor reported that only 10 of the top 40 popular CDs on sale during the 1995 holiday season were free of profanity, or lyrics dealing with drugs, violence and sex. (2)
- A recent survey by the Recording Industry Association of America found that many parents do not know what lyrics are contained in the popular music their children listen to and are intimidated from finding out. (3)
- In September 1995, Warner Music Group bowed to public pressure and announced it was severing its 50% stake in Interscope Records, home to Nine Inch Nails and controversial rap artists Snoop Doggy Dog and Dr. Dre. Rap artists simply turned to a different distribution network and their

CDs continue to hit the stores with lyrics which glorify guns, rape, and murder. (4)

NOTES:

1. Entertainment Monitor, December 1995.
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